result of special condition of the water sources of the area. The water in the area should be well protected. Ghazni is densely populated area and the kariz water passes through many villages. Typhoid can be controlled if the water is protected right from the spring. This remedy must be considered seriously.

Cholera is registered in Helmand, Kandahar and Oruzgan clinics. The incidence of cholera is seasonal and constant each year especially in Sep and October. The highest number of people affected by cholera are in Oruzgan and then in Helmand. It includes all categories of the patients, especially men and women while children show a lower incidence. This problem should be assessed carefully if it is to be effectively controlled.

The following comments are possible solutions for some of the above problems :

1- Special programmes (e.g. refresher trainings) should be arranged for to upgrade the qualification of the MLHWs for inside clinics.

2- Tn the refresher courses information on children diseases (0-14) and their diagnoses should be included in a broader form.

3- The MLHWs in provinces of Oruzgan, Kandahar and Helmand should be encouraged to make more accurate diagnoses, and prescribe medicine effectively in order to economize on use of medicine and avoid side effects due to giving wrong or multiple medicines.

4- Those clinics which have been identified as having lower efficiency according to the research, should use registration cards to charge the patients, and therefore reduce the numbers coming who arenot really sick.

5- The clinics in Oruzgan and Kandahar should be equipped with lab facilities especially for TB & Malaria diagnosis to enable them to diagnose these cases precisely.

6- Clinics as well as hospital staff must arrange a regular health education programmes through propaganda in public places and in schools. They should explain basic health rules and the control of diseases.

7- Vaccines all target diseases of EPI, should be sent as soon as possible and spreading of information about importance of immunization should be encouraged.

8- Malaria control is a vital need of all the areas and if medicine is provided at a cheaper price local people will be able to help control the malaria. Health education is also important in this regard.

9- In Ghazni karizes are the main source of water. To control typhoid and diarrhoeas especially, pipes with filters should be drawn from the origin of the springs up to the villages. This work is possible with the cooperation of the community.

10- To reduce intestinal worms, medicine and health education for families play an important role.

11- To overcome the malnutrition problem, providing information for the community on family planning, mother and child care will help considerably.

12- The suggestions in article 11, will also help reduce the level of the patients affected by anemia.

13- For gastritis and hearburn dietary advice should be given with certain medicine which will help to alleviate this problem.

14- If possible, with the cooperation of local communities, female health workers should be trained to run clinics specifically for women which will help improve their health care.

15- In order to know whether it is really cholera which exists, a special study should be carried out in Oruzgan, Helmand and Kandahar provinces. Effective control measures can then be applied.

REFERENCES

- "Afghanistan" by Louis Dupree 1980.
- "Afghanistan On The Path Of History" by Mir Ghulam Mohammad Ghubar, 1971.
- "Afghanistan The Great Game Revisited" by Rosanne Klass, 1987.
- "Afghanistan's Population Inside & Out" by Thomas H. Eighmy Ph.D, 1990.
- "The Reconstruction of Afghanistan" UNRISD Report by Hanne Christensen, 1990.
- "Preliminary Report on Conditions Affecting the Repatriation of Afghan Refugees" UNHCR Report, by Richard English Ph. D, 1988.
- "Afghanistan Annual Report", Ministry of Information & Culture, Kabul, 1974, 1971.
- "Annual Report, UNHCR" , 1985, 1986.
- "UNOCA REPORTS", 1990, 1988, 1989.
- "MSF Survey Among Un-Registered Afghan Refugees" by MSF Team, 1991.
- "Pakistan Studies, Compulsory, Lahore, 1987.
- "The State of The World's Children" report, 1990.
- "The Children of Afghanistan,International Hearing" Stokholm April 4-5 1987.
- "IAHC Helmand Project Monitoring & Supervision Report", From Jan 8 to Feb 21, 1991.
- "IAHC Ghazni Project Area Monitor & Assessment Report From 17 June to 21 July. 1990.
- "IAHC Survey Report Panjwai & Maiwand Districts, From 24 Jan to 22 Feb, 1990.

and shape its culture and social forms. Complementing each other, patriarchy stands side by side with the landlord system. The fact behind it is that over 85 % of the Afghan population resides in over 21,750 rural communities. These communities entirely survive by the revenue from agriculture as well as livestock. Lack of easy access to the cities, a very low standard of communication and transportation, little formal education, faint, sometimes complete lack of central power (in its real form) all contribute to the strong position of landlords as well as their counter parts. They rejoice in governing the villages, especially the poor peasants.

In Afghan society, inheritance passes from father to offspring. Since the father is the bread winner, so his such a vital role in the family, eventually making him important in every aspect.

He has to find wives for sons, and husbands for daughters. In most of the families, the boy and the girl who are getting married are not asked for their own choice at all.

In 1970s 1/3 of the population married before the age of 20. 1 to 2 % of the adults remain unmarried (1981 Government of Kabul).

Early marriage is very common especially in the rural areas. The girls are often married just after puberty.

By 1979 over 15 % of Afghanistan's population was urban living in cities of Kabul, Kandahar, Herat, Balkh, Jalalabad, Lashkar Gah and 57 towns whose populations were more than 50,000 and 2500 to 50,000 respectively (UNRISD report Hanne Christensen, 1990).

WOMEN IN AFGHANISTAN

Background :

For the first time in modern Afghanistan Amanullah Khan proclaimed the independence and the equal rights of women with men. By 1921 the first women's school was opened and eventually the women had a chance to study abroad.

This progress was interrupted by the strife led by Bacha-e-Saqao (1929). Nine months later, all previous reforms relating to women were halted and Islamic laws were reintroduced to reinforce women's traditional position within the family and society.

In 1964 women were recognized as equal to men in law and they were given the right to vote.

From 1965 to 1972 four women took important positions, two became ministers. In 1971 the marriage law was amended.

After 1978 coup, more radical reforms were launched by the PDPA Government which outlawed forced marriage and the practice of levirate (whereby a woman after her husband's death, must stay with his brother or brother's son) was prohibited. (Hanne Christenseh UNRISD 1990)

To bring in a reform, was quite a revolutionary process for the past governments. Many reforms failed to bring a change in women's attitude and every time the traditionalists won.

The only way to induce change was for the past government's staff or officials, to send girls to school and gradually the surrounding people were encouraged to

educate their sisters or daughters. This process developed and finally a number of women were able to be active in social affiars.

In 1946 a women's association was opened called Reyasat-e-Da-Mermano Tolana (Directorate of Women Assosiation). It was supported by the government at that time with the assistance of some of the international organizations such as UNICEF.

It was the intention of this association to upgrade women's living standards, in terms of education, training in skills, intellectual development and Mother and Child Health Care. (Annual Report G. of Kabul 1974).

AFGHAN WOMEN TODAY

At present in Afghanistan, the status of women varies from one ethnic group to another, from urban life to rural, from one tribe to another and one area to the other. The women's condition also depends on the community-'s culture, economy, historical background and other fact affecting women's daily life.

As women are a heterogeneous group,in one community women are very restricted and must stay in the four walls of their house. In another, women are found sowing, planting and weeding, and may grind the wheat to produce the flour.

Women are directly resposible for the care of their children. Especially after the war killed and maimed many men, who were unable to support their children.

Health problems among women, are very controversial and significant. High levels of illiteracy as well as lack of mobility due to traditional seclusion, all

contribute to the high rate of fatal diseases among them. Later, we will discuss the women's health problems in more detail with some statistics.

Education as mentioned before, is not in a satisfactory state at all. According to UNICEF (1990), 8 % of women are literate as against 39 % of males. By 1988 a total of 21 % female are literate as a percentage of male. The primary school enrolment ratio in 1988 was grossly 14 % female as against 27 % male.

The employment rate for women in Afghanistan, is very low. Most of the women are employed in large cities. Women in rural areas are often self employed. The labour market mainly consists of men; about 70 % of the adult male population was considered economically active. In contrast women were estimated to be less than 8 % employed (Government of Kabul 1981).

The rural women are mainly active in embroidery from Herat in the west upto Kandahar and Zabul areas in the southwest. In the north the Turkamen immigrants brought probably in the 1920s the carpet industry. Hence generally women are involved in producing carpets in those areas.

It is estimated that women constitute 87 % of the workers producing hadicraft items for sale (Hatch Dupree 1989).

At present, in Afghanistan, women make 50.2 % as against 49.8 % men. While before 1979, the population was estimated to comprise 51.5 % men and 48.5 % women which was according to socialogists, a normal ratio, (UNRISD report 1990).

Women play very impotant role in Afghan society. They shoulder very great resposibilities in both the family

and society. The girls who are married, are the links which build kinship between individuals, families and even tribes. From dawn to dusk they ceaselessly work. Taking care of their children, animals, cooking with fire wood and sometimes helping husbands, brothers or fathers working the land. Old ladies also teach children the Quran, while young women work in the house, besides producing embroidered handicrafts.

But still, they receive half even sometimes 1/3 of the share of the earning. The majority of women accept it as an inevitable way of life. In many cases men are found to be very cruel to their wives or other female family members; in fact a man is expected in many rural but rarely in urban areas, to beat his wife, sister and other female members.

By contrast, love, in an Afghan family, is very powerful. Since a woman often devoted her whole life to her husband, so her husband becomes everything for her. The same is the case for the husband. A man is always trying to improve his family's life and ultimately bring happiness to the family, because the tradition has made him the earner for children and wife.

The more he earns, the more he is able to feel proud and enjoys respect from the family members. Though leaving a family in Afghan society is traumatic, still many youngmen, leave for abroad as manual labourers and skilled workers.

WOMEN IN EXILE

The infrastructure of the Afghan economy has been considerabley damaged. Therefore, the society has suffered unprecedented social disorder. Thousnads of youngesters

have been conscripted by the army, decimated by continuous bombardments, face to face fighting and other causes. Women were left behind wondering whether to flee and join the influx of refugees to Pakistan, Iran and elsewhere.

The chaos was so bad that they were left no choice but to leave. Hundreds of thousands of women with one, two or more of their men, fled to Pakistan and Iran and to western countries, soon after the 78's coup.

Spending years in conditions of great hardship , women adopted a completely new way of life. In Pakistan and Iran over 80 % of Afghan women live in condtions of absolute poverty (Hanne Chr. UNRISD report 1990).

The constant threat of hunger, lack of water, increased seclusion emposed by male members of family, problems with children's education, health, raising costs of accommodation etc, all toture them physically and mentally everyday.

At present, women are estimated to constitute over 60 % of the refugee camps population. According to UNOCA there are 700,000 (approximately) women, widowed.

Hanne Christensen, in her report says that "many women are earning money from handicraft productions. It is estimated that 9.5 % of girls are self employed in making handicrafts. About 2 % of the refugee women are thought to have been working as casual labourers, and maybe less than 1 % employed in Health Services permanently ".

Later she writes that most of the women earn less than $ 8 per month. Only 5 % can earn enough to support a family of 6 to 8 persons. She states that roughly 64500

women are in the labour market, of which 62800 are self employed ; 1300 work as casual workers and around 400 are in permanent employment mainly in health sector.

CHILDREN

From 1978 till the present day, a generation has been born and raised watching war, killing, torture conscription and destruction of their school. Hate and revenge fill the Afghan children's minds. Increasingly parents are unable to support their children because of the war's disasterous effects on every aspect of life. If the father is killed, the children's condition is even worse.

Children are still directly or indirectly involved in fighting, and in this crucial role they contribute to the future of Afghanistan. In fact Afghanistan will eventually be rehabilitated by today's children.

The presence of children in the family, is regarded as vital and they are the pillars of the parents. The cultural and rural economy has made male child important, and therefore a boy's birth is more celebrated. Children constitute a large proportion of the country's population.

After the Russians invaded into Afghanistan, they came up against the strong family ties between children and parents. They deliberately wanted to break these ties, but contrary to the Soviets' expectations, children joined parents against the Russians.

Kabul was different from other provinces. Many army staff's children became orphans. These thousands of orphans as well as other children whose parents could not take care of them, were sent to the Soviet Union every year. They are trained and educated by Russians. Most of these children have now grown up, not knowing about their country's history

and even about the resistance of their own people against Russians. On the other hand, in Pakistan, thousands of children are being taught and trained in maddrassas supported by the parties. Almost, all of them are ignorant of the country's history and real Afghan culture.

A small number of children from well off families are enrolled in Pakistani schools. They are taught Urdu and are completely unaware of what has happened and what is happening at the present time in their country of origin.

All these problems relating to children, contribute to the disintegration of the Afghan society. This is the time for Afghans to give a helping hand, but in practice, it seems quite impossible, unless an impartial or neutral educational system set up to tackle and arrange all educational activities under one policy.

The other outstanding problem among children, especially in exile, is that, daily children over 12 yrs are becoming addicted to heroin or chars. Some come out without their family's permission, to beg. There are also many thousands of children who rushed toward cities to work as apprentences or cleaners in teashops, hotels, bakeries, and as labourers in small and large industries of Panjab and Sind.

Most of them escaped poverty and left behind their families. There is a large number of children collecting rubbish papers from the market corners and rubbish cans in order to make money.

This status of the Afghan children affects their character and moral. Most children can see no hope for their future.

The enrolment in education both in Pakistan and Afghanistan in below 20 % of all children.

Afghan society's future can be predected from the status of its children today.

Let us hope for the best and quickest solution to the recent crisis and have all society's members gathered and committed to rehabilitate their country together.

AFGHANISTAN ECONOMY

Afghanistan covers an area of 650,000 km^2. The northern and eastern parts of the country are occupied by the high ranges of the Hindu Kush Mountains, while south eastern area is shaped by a vast desert.

About 43 % of the area comprises regions over 1800 m above sea levels, including 10 % higher than 3000 meters. Some 46 % consists of hilly elevated areas at an altitude of 600 to 1800 m, including 1 % below 300 meters (Humlum, 1959).

Amu Darya in the north and Helmand Rud in the south are the most valuable water sources of the country. The Kabul river forms in the highlands of Parwan and runs through Kabul city and finally crosses the Afghan- Pak border from Jalalabad to Peshawar.

Arghandab has its source in central Afghanistan, runs through Zabul and Kandahar and finally joins Helmand Rud. Harirud originates in the north west and waters the vast lands of Herat.

The most important mountains of Afghanistan are; Hindu Kush, north east (6298m) ; Kohe Baba, central Afghanistan (5143 m); Bande Turkistan, north, (3497 m); Fayroz Koh, north west (3588 m).

Afghanistan due to long and dangerous games with the world's super-powers, which has cut it off from its terretories, has become landlocked (Gandamak Agreement by A. Rehman's Government, determined by Durand 1883).

Afghanistan is a typical agricultural state. About 85 % of the population which is living in rural areas, is involved in agricultural activities directly or indirectly.

Until 1974, Afghanistan could produce 88 % of its

AFGHANISTAN HISTORICAL BACKGROUND

Afghanistan as befits a vivacious state and mother of different civilizations, has had many different titles such as Aryana (1000 BC to 5th Century AD), Khorasan (5th cen to 19th century) with Afghanistan the official title announced in the 19th century.

The rough and high mountains of this country has created a harsh atmosphere with proud and unruly poeple.

The inhabitants of old Aryana have fiercely defended their country from all outsiders from that time until now.

To illustrate this, let us go back through some pages of the tubulent, yet artistic history of Afghanistan.

Afghanistan's archeological experts have found evidence of Paleolithic and Neolithic cultures. It is said that the earliest known piece of Asian portrait sculpture, carbon-dated to 20,000 BC, was found in Afghanistan.

By 3000 BC, Afghanistan was the cross-roads between Mespotamia, Persia and the civilization of the Indus Valley.

By 600 BC, Zoroastrian religion appeared and spread to some parts of old Persia.

During the 6th century BC Buddhism influenced old Bakhtaria's civilization.

Later (329 - 326 BC) Alexander the Great invaded Afghanistan on his way to India. The invasion left behind considerable cultural changes in the local civilization which were eventually integrated with the pre-existing Buddhist civilization

required wheat. So it was regarded as a self-sufficient agricultural state, (Annual report G. of Kabul, 1974).

By 1974, of the total land in the country, about 7.8 million hectares (12 %) was under cultivation. Of which 5.3 million hectares had irrigational facilities, but according to the Government statistics in 1974, every year, only 2.5 million hectares land was being irrigated because of shortage of water.

Throughout the country, about 70 % of the total land is being irrigated. Rain-fed cultivated land makes up 30 % of the total tilled land, about 1.55 million hectares. The main rain-fed crop is wheat that occupied about one million hectares land (Government of Kabul, 1974).

Many areas in the country have cold climate which makes it difficult to cultivate for more than one season. While in the southern parts of the country, farmers can cultivate for 3 seasons a year. This is very beneficial from an economic point of view. Population growth is also affected by the warm climate.

Wheat cultivation is common at altitudes between 300 m to 330 meters. The staple crop is wheat, which is of one of the highest qualities in the world.

Fruit export makes up 20 - 50 % of the foreign currancy income in Afghanistan. By 1974, according to the government of Kabul, from statistics at that time, 1/3 of the fresh grapes produced were consumed and exported while the rest were dried.

Regarding natural resources, forests occupy about 1.8 million hectares area in Afghanistan. The forests are mainly situated in parts of Paktia, Laghman, Nengarhar and Badghis (Government of Kabul , 1974).

Pastoralism has also been an integral ingrediant of the economy of Afghanistan throughout the centries. According to the government in Kabul, almost 85 % of the population livestock to some degree, depedding on the economy and avialability of pasture land.

In 1974 there were about 30,000,000 domestic animals, of which half were sheep, 6.4 million Qara Qul sheep 3.6 million cows and oxes, 3.1 m goats and the rest other animals, (Annual report G. of Kabul, 1974).

This report says that the annual wool product was about 17000 tons of which 5000 tons were being exported.

The existance of mines and gas in the north have also contributed to the improvement of Afghan economy. Recent researched carried out by the Afghan and Soviet geologists (1977) indicates the following mineral sources in Afghanistan :

- 58 solid combustible materials.
- 898 different metalic minerals.
- 4 radio-active elements.
- 105 precious metals.
- 118 non-metalic minerals including 31 chemical raw materials.
- 2 mineral fertilizers.
- 80 other non-metalic minerals.
- 20 precious and semi-precious stones.
- 23 electronic and optical minerals.
- 69 industrial materials.
- 29 other mineral sources, and
- 14 salts.

Manufacturing in Afghanistan, is a small feature of its economy, developed as early as 1880s. More progress was made after 1940s, when some industries were introduced.

Upto 1974, there were 20 textile manufacturers in Afghanistan. As an example, according to annual report, in 1971, Afghanistan produced 62 million meters cotton clothes, 10.5 million Sundi cloths and 2,84,000 m woollen products.

Afghanistan has been much influenced by the Soviet Union, in its foreign economic policy as well as in home politics. From the early 1950s Russians stood as the power in the region; they had very good opportunities in developing countries, especially in Afghanista. As a result, in December 1955 Nikita Khrushchev and Nikolai Bulganin visited Kabul and offered the Afghans a $ 100 million loan. Later, by 1967, the Soviet credits to Afghanistan totalled $ 570 millions. By 1978, the total Soviet loan raised to $ 1.265 billion.(Afg.The Great Game Revisited, by Rosanne Klass, 1987).

As an example, from 1979 to the end of 1984 the Soviet export to Afghanistan totalled 1,892,439,780 dollars which were consist of ; Machinary, equipment, vehicles geological equipment, drilling and extraction, aircrafts, trucks and petroleum and its products, (from above book).

Since Afghanistan could not pay back those huge debts, so almost all exportable raw materials were exchanged for the imported Soviet commodities. Such exploitation of Afghan resources, eventually led to the destruction of the economy of the country.

Politically, up to the present time, Afghanistan has been trampled by continuous Soviet intervention into its home affiars and iternational as well. Consequently, this country lost its non-aligned position.

Hopefully, in near future, Afghans all be able to restore the non-aligned position of their state once again.

EDUCATION

Education in Afghanistan has been a very controvertial issue. As mentioned before, several factors have contributed to the current state of education.

Firstly, the strong traditional life style of the majority of the population, slowed and sometimes stopped the growth of formal and progressive education. An ilogical fear that the children would breakaway and not continue the traditional way of life, especially as regards their obedience, provoked many local influencial leaders. Ultimately, they forced the past governments to stop the campaign against illiteracy.

Secondly, in some areas traditional prejudices which backed sometimes by wrong interpretation of religious laws have also contributed to the very slow growth of contemporary education.

Thirdly, the poor status of the Afghan economy, has also contributed to the slow progress of education, especially in rural areas. The past governments have been complaining about lack of funds for supporting educational centres in general.

The recent statistics shows that in 1974 the enrolment rate was 20 % of the children between 7 to 12 years of age, (Annual report G. of Kabul, 1974).

By 1978, the level of enrolment claimed upto 30 % which shows 10 % increase in comparison to the prior level. According to UNICEF (1990), about 39 % of male population over 5 years of age, was literate, compared to only 8 % of female population.

However, these figures are only estimations which are not fully reliable and yet show facts which can not be ignored.

Not surprisingly, due to the poor condition of education, there was considerable drop out of the students already enrolled. In 1974, 30 % of the students dropped out because of failure and other causes.

Higher education in Afghanistan, was formally developed in 1932 when the Kabul University was established. The western countries as well as UNESCO contributed to the progress of modern studies in the country.

Later within the University, the following faculties were opened ; Faculty of Medicine (1932), Science (1942), Literature (1944), Agriculture (1955), Engineering (1956), Economics (1957), and other small faculties.

Besides, an university was set up in Ningarhar in 1963 and soon after an institute called Polytechnic , was established in Kabul (1967) with the assistance of the USSR, (G. of Kabul, annual report, 1974).

According to Professor Elmi, there were a total of about 1450 persons on the staff including teachers (foreign & local) translators and other managerial staff.

Moreover, by 1974, there were 10 Darul-Malemin (Teachers Training Institutions) throughout the country. These centres were training high school graduates for two years.

In addition to those centres, there were other technical training schools as well.

According to the figures we obtained in this report the education status in general was rather poor, but it should be mentioned, however, that quality of education in Afghanistan was superior to the quantity available.

The rest of the population mainly in rural areas had no access to schools and have been suffering from

illiteracy of almost hundred percent and have been deprived of technological facilities and other developments which exist in the cities.

Most of rural children including a few girls are being taught at the local mosques. The mullahs have inadequate curriculum to educate the children and there is no writing or scientific teaching system at all.

During the last 13 years of war, education at all levels has been seriously affected. Two-thirds of the schools have been abondoned or destroyed. The enrolment rate estimated to has dropped from about 30 to 18 percent. At the moment girls constitute 1/5 of students. (Hanne Chrestinsen UNRISD, 1990).

According to Professor Elmi, of some 750 University teaching staff in 1978, almost 37 % are now in exile.

Afghan children and youngesters in Pakistan and Iran are also suffering from a lack of facilities, qualified teachers, standard curriculum and other problems. Each party has its own teaching system in Pakistan and with separated curriculum. Relief agencies also train in different ways. The camp children are mainly being trained in party supported schools and in mosques. While in large cities many children have been enrolled in Pakistani schools.

EFFECTS OF WAR

As mentioned before, the Sour 1978's coup and consequently the 100,000 Russian troops' invasion of Afghanistan, resulted in the exodus of over 5 million to Pakistan, Iran mainly and some to other western countries. About 3 millions are estimated to have been displaced inside the country to more secure areas.

The deliberate bombardments of the air-force on rural as well as towns, killing of civilians in prisons and other causes, decimated over a million Afghans during the past 12 years. Of which about 300,000 estimated to have been women. Along with such decimation, almost 2/3 of the 22,750 small scale villages or communities have been destroyed or abondoned, (UNOCA , 1989).

Agriculture, the life blood of the Afghan economy, is the severely affected sector. It is estimated that over 50 % of the arable land has been destroyed or abondoned.

According to some sources, it is reported that the reduction in outputs are : for wheat 80 % ; for corn 77% ; for barley and rice, 74 % each. It is estimated that the labour supply available for cultivation has been fallen by 52 percent.

The Russians depopulation policy of the rural areas, affected especially, the southern border provinces which are stretched along Pakistan's border. Of these provinces, Kandahar is the most damaged area in comparison to its neighbours. Kandahar's 420,000 refugees in Baluchistan constitute 10 % of all refugees in Pakistan.

Not only humans but animals have suffered from the indiscriminate and numerous buried mines. An estimation

shows that around 5 millions domestic animals have perished within the period from 1978 to 1984.

This war through out the country, killed three times as many men as women, which as a result changed the normal ratio of the pre-war population. By 1987 it was estimated that women were in majority, 50.2 % as against 49.8 % men. While in the year 1978 men comprised 51.5 % against 48.5 % women, (Slivinsky 1989).

According to Sliwinsky (1989) about 300,000 persons have been maimed; most of which are women and children.

The intensive fighting forced a great number of people, to flee to major cities, especially Kabul. According to UNOCA the Kabul population is estimated to have sowllen to 3,000,000 people.

Socially, all the Afghan society is suffering from disorders in every aspect of life. Families have been split up. Thousands of parents have not seen their children, for even 10 - 12 years. Some have no news from their family members at all. The prisoners have also been crually kept by the Kabul regime, and kept in ignorance of their families.

Politically, among thousands of young people, the seeds of enimity have been dissiminated by following different parties and these hostilities will directly affect the future of their service to Afghanistan. Yet in any society if efforts are committed honestly, it is possible to cope with the problems it faces. So remarking this fact, Afghanistan could be rehabilitated by the efforts of Afghans themselves with the help of international communities.

HEALTH :

After the 13th century, when Afghanistan was trampled by invasion and fighting, much academic development had been destroyed. The Oriental scientific growth of all branches of science including medicine were generally seriously affected in the country.

Consequently, a depressed period hit the area and a wave of superstitious methods of treatment as had been common in the past, prevailed. Very few scholars after the 13th century could study abroad, where knowledge was at least developing scientifically.

For the service of government and higher authorities, some scholars were being trained in Bokhara & other places, to be medical practitioners, (tabib-e-yonani).

This system was common until 1932 when for the first time modern medical institutions were introduced in the country.

But many rural people in Afghanistan still take a vaiety of approaches to health care. Home treatments included bed rest, prayer and vows, dietary prescriptions following the Greek humoral beliefs of hots and colds, herbal medicines and special treatment for particular ailments. They attended Basic Health Centres where these were available, but BHU's were not within the reach of most of the people.

Village-level health services were obtained from dais, barbers, injectionists, pharmacists, traditional medical practitioners, herbalists, and bone-setters. City and town people additionally visited modern practitioners, clinics and hospitals.

The introduction of modern institution in the field of medicine in the 1930s, resulted in the production of qualified doctors. By 1974 the country had a total of 1186 highly qualified doctors.

As the doctors were trained mainly from the large cities, they were generally appointed to civil hospitals, many still under construction.

Other towns also eventually developed primary health centres, but these centres only rarely had a qualified doctor trained in Kabul or subsequently in Jalalabad.

Almost all primary health centres were run by nurses, who had two to three years training in Kabul and other large cities.

According to the Kabul Government Report in 1974, the country had 66 hospitals in total and 130 health centres. All these hospitals together, had a total of 2741 beds, allocated by the ministry of health.

Allowing for a 15.4 % increase in the number of doctors produced by the medical faculty of Kabul as well as Jalalabad; and to extrapolate it, by 1980 the total no of doctors would have been expected to have been 2027 persons.

When distributed among the population, in 1980 there would be one doctor for every 7943 people.

As is of the case in developing countries, the Afghan population has been suffering from many preventable diseases.

According to the UNHCR health report (1986) the following information on the nature of rural health problems summarizes the health status and services in Afghanistan in 1977, was stated :

Koshanian, the Sity tribes , emerged and ruled the country between 40 and 220 AD. The most brilliant era was of Kanishka. The Bamyan Sculpture (statue) is one of the mostimpressive signs of the art from that time. This art and civilization in general was more or less continued until Islam succeeded in the 7th century.

The greatest impact on Afghan society was the succession of Islam over the country, which is still in a strong form today (2nd half of the 7th century).

The Ghaznavid era (962 to 1148) is regarded as one of the greatest and most powerful of the monarchies in the east at that time. Generally art and philosphy were remarkably developed.

The greatest known poets, philosphers and artists of the Ghaznavid era and afterwards were : Mowlana Jalaluddin Balkhi, Ibne Sina-e-Balkhi, Nasir Khisro Balkhi, Abo rihan Albironi, Ferdowsi, Sanai Balkhi, Abo Nasre Farabi, Zekria-e- Razi (famous chemist), Ibne Khalidon and others.

By 1220 the country was invaded by Genghis Khan who eventually slaughtered the population, cities were burned and most scholarly sources were destroyed.

Amidst the ruins of Genghis Khan, the Afghan nation arose again and there was eventually created, an Emirate in Herat called Gorgani (1404). Amir Ali Sher Nawai, a prudent Amir, restored conditions able to redevelpp the old artistic era once again. Behzad, the greatest portrait painter of this time, gave the world of art a surprise.

In 1709, after a long resistance, the Safavid troops from Persia led by Gorgin, were defeated in Kandahar and killed, and by the effective leadership of Mirwais Khan the first Afghan government was established amongst the Pushtuns.

Chapter II

IAHC Health Projects Research & Interpretation

Projects in
Ghazni, Helmand, Kandahar,
Urozgan and Quetta

* Infant mortality rate culculated at 157 per 1000 live births.

* More than half of all deaths occur to children under five years of age.

* Symptoms suggesting tetanus (29.6 %), respiratory diseases (17 %) and diarrhoeal diseases (11.2 %) account for 60 percent of deaths of children under 5.

* Respiratory illnesses (20.4 %), diarrhoeal diseases (17.3 %) and symptoms suggesting tetanus (14.3 %) account for over 50 % of all deaths.

* Women aged 30 to 45 have a rate of reported illness almost twice that of men of the same age.

* Fewer than 60 percent of children in any age group are classifiable as well-nourished according to arm circumference measurement. More strikingly, less than 10 % of children 1-3 years of age are classifiable as well-nourished.

* High protein foods are not introduced into children's diet until almost two years of age which is the normal breast feeding period.

FOREWORD.

In this writing, we would like to present you with information and its interpretation on the themes of health care, diseases, diagnosis, treatment, available facilities, and the huge inadequacies which exist in Afghanistan.

Having considered the general information on Afghanistan which was previously presented, it ought to be mentioned that the health and its present problems among Afghans inside the country and in Afghan refugees, are almost entirely the result of war sustained throughout the nation.

According to the philosophical principles of social studies, any problem in a society is a consequence of all the existing conditions of that society. Therefore when considering the health conditions of the Afghans, we should agree to accept that these problems are the result of the conditions in which the Afghans live. Based on this fact, we have tried, at the beginning of this book, to include some facts on the history, culture, geography, education, economy, agriculture and other factors of the Afghan society.

In today's situation, when the Afghan health problems are considered, they (health problems) as a whole , are the consequence of a combination of the pre-war situation and the disasterous condition after the 1978 coup. So along with other disorders in Afghan society, health has also moved backwards.

It is clear that after the 1978 coup, the majority of Afghan muslim people, according to their religious and traditional principles, regarded it as their duty to

eliminate the communist government as well as its Russian supporters.

As soon as the war against the non-muslims was started, the Afghans called this war "Jehad" and the person who took part in it, was called a"Mujahid."

The common goal for all the Afghans including mujahideen was to restore a government accepted by all the people, which would be based on their religious and historical patterns.

According to the available statistics, upto 1979, about 15 % of the population mainly urban citizens and inhabitants of surrounding villages were literate. Since the resistance formed amidst rural people, the educated people were rarely found in the mujahideen groups. Moreover, the educated minority, being sensitive to the situation, took refuge far away from the country or were employed ouside the country e.g. Pakistan.

The destruction of the system of cultivation, trade, education and other public services are all causes of the increasing health problems. The demolition of the irrigation system as well as the eradication of trees and bushes has also directly caused the emergence of stagnant water, which were sources ofor malaria, leishmania and spreading of other diseases.

The loss of cultivation,of land, trees and other vegetation which played an important role in air filtration, has caused an increase in air pollution by gases and poisonous smokes.

The hard life-style of the rural people and mujahid groups, especially their movement and even immigration to different areas with different cultures, also contributed to the spreading of diseases.

According to some reports , A.I.D.S. is not yet recorded among Afghan population.

What IAHC would conclude from its experience of working for 11 years in Quetta, Pakistan and inside Afghanistan is that many organizations (e.g. UN agencies, NGOs etc) have endeavoured to improve the health situation,but lack of infrastucture as a whole and facilities particularly for health, have minimized the result of this assistance.

More specifically, the war caused a great need for medicine and health workers which was secondary in importance to the need for weapons.

For the purpose of dispatching primary health facilities to the war victims and other patients inside Afghanistan, there are 6,500 (WHO report) persons who have been trained as primary health workers. Such training of health workers, is certainly an important contribution but lack of control and unlimited use of medicine has caused new health problems. The resistance of some of diseases against treatment (e.g. wrong treatment of diseases and too much use of antibiotics), unnecessary prescriptions and distribution of medicine which have side-effects brought about high mortality among local people as did usage of expired and toxic medicine, and treatment by unprofessional people, all these factors together caused new health problems among refugees and inside Afghanistan.

It is also importantto mention that incomplete treatment of some of contagious diseases i.e. tuberculosis is a common problem. The unprecedented rise in the number TB patients has been caused either by wrong diagnosis, incorrect or incomplete courses of medicine, or perhaps by carelessness of patient in taking medicine. Other important

reasons are the bad economic conditions, psycological problems and the cultural in which the patients are living now, in comparison to the prewar situation.

The lack of complete or inefficient use of vaccin -es for women and children has increased the rate of mortality and morbidity from contagious diseases among children.

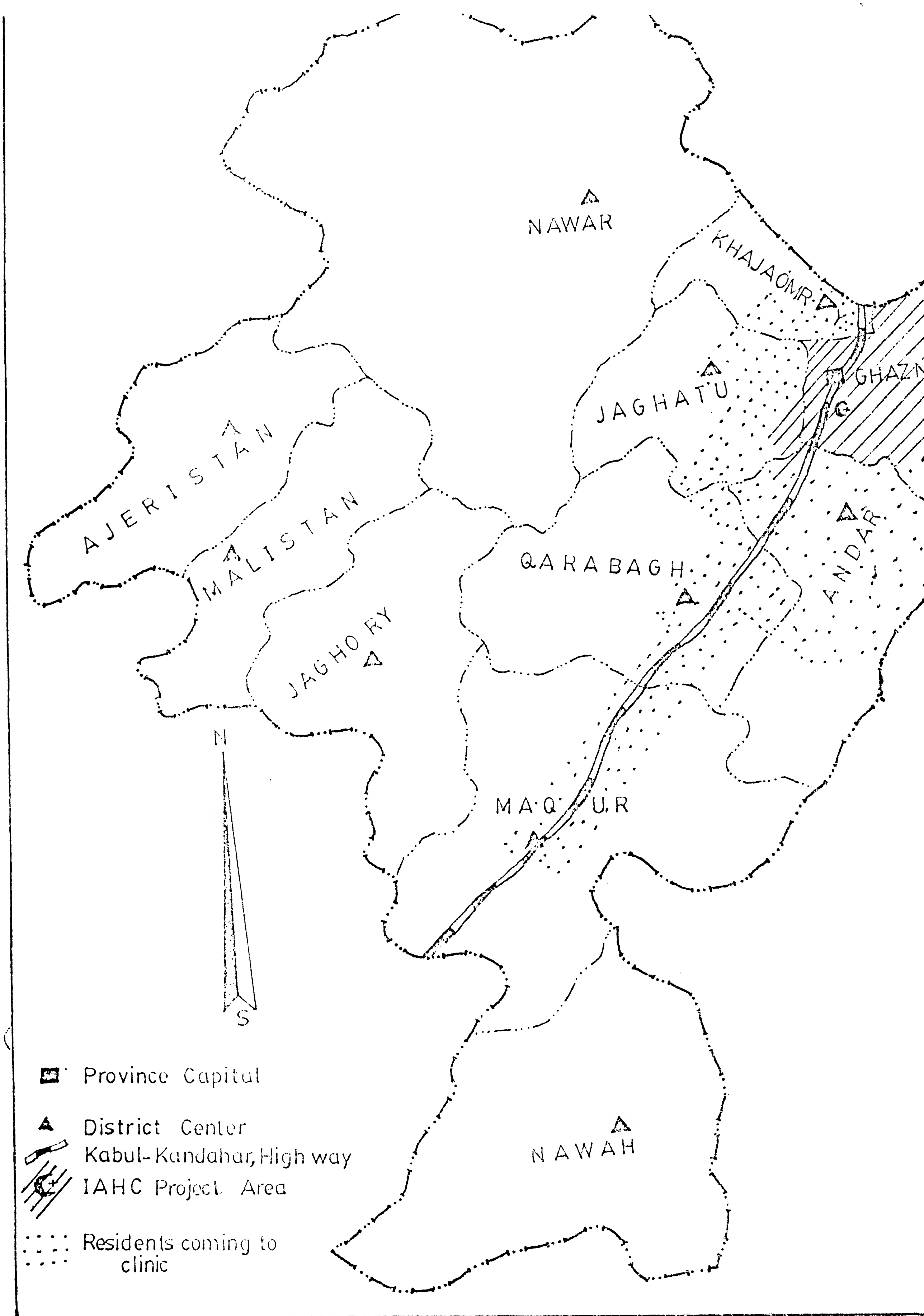
The sudden and unexpected recession of education and the limited sourse of public teaching, has affected the public knowledge which has as a result caused a rise in different diseases especially diarrhoea, malaria, cholera and other parasitic problems.

As mentioned before, along with other aims, one important intention for producing this book is that to make a new list of medicine according to the diseases and their percentage in each area. In this way, the extra and unnecessary dispatch of medicine to an area can be avoided.

Since a medical report is a result of medical staff activities, IAHC can identify the weak points of the staff work and guide each project to better ways of diagnosis, treatment and use or prescribing medicine. Thus discussing new points with the medical staff and local people, provides improved health education.

Finally IAHC can conclude from the medical reports they obtain, how much a patient is helped or supported. The understanding of the cost of each patient to a clinic will be the basis for the future plans of a project. Those who are responsible for the projects with the cooperation of local residents and IAHC advices, ways should be searched to exploit our own financial sources and develop them, so the project will finally be financially self supporting. Based on this fact, and considering correct and complete

treatment of diseases as far as is possible unnecessary use of medicine should be prohibited to enable us to find out the correct expenditure of each project. Then each project could design its own future plans.


NAWAR
KHAJAOMR
JAGHATU
GHAZN
AJERISTAN
MALISTAN
QARABAGH
ANDAR
JAGHORY
N
S
MAQUR
NAWAH
Province Capital
District Center
Kabul-Kandahar, High way
IAHC Project Area
Residents coming to clinic

GHAZNI

To enable an accurate interpretation of the IAHC medical research from inside Afghanistan and Quetta Pakistan, it is necessary to be familiar with the environment of the areas where the clinics are located. In particular regarding the ecology, costums and traditions, education, the way of living, the effects of 12 years war, cultivation and water sources.

Hakim-e-Sanai Policlinic from 1985 has been constantly in Espende Village 9 km south west of Ghazni city.. An area of 20 km, in which about 28,000 families (1,95000 persons) are living, uses and benefits from IAHC Policlinic services. This area includes Ghazni city as well as the surrounding districts. These villages are stretched over flat and level areas, and are surrounded by high mountains. The altitude of flat areas from sea level, is about 2100 meters. The Ghazni and surrounding areas have a dry climate with hot summers and snowy winters. There are rains from 10 March to the end of April and in authumn from the beginning of November up to the middle of December.

The soil contains fine sand and when there is a wind, dust always pollutes the air. Almost every mid-day in the summer, there are cycloinc winds. Windstorms also occure which not only pollute the air, but also change the temperature.

With the exception of Band-e-Sarde 27 km east of Espende village, residents of all other nearby areas use kariz and stream waters which are drawn from the seasonal river. The Ghazni seasonal river runs from October up to the middle of June and has no mires except in some parts of Pir - Shahbaz east of Ghazni city, Chelam Shahr and southern course of the river in Qala-e-Hakim. During summer,

these are suitable places for malarial mosquitoes to lay eggs.

As mentioned before, the major source of water is karizes. There are villages built beside these karizes and as water passes the villages, there is 90 % chances of water being contaminated. The water is used by humans and animals at the same time. Women wash their clothes in this water and the wasted house water also joins the stream water. For example, in the lower parts of the Espende village, where there is water flowing through it, all the residents use this kariz water in their houses; the more the water travels into the village, the more it becomes polluted. During visiting this village, it was notices that the houses on the lower parts of the river, had many typhoid patients. But contrary to that, the first houses which use the upper water, had no such signs or were very few.

Being poor, the houses are mud built and in addition the rooms are dark with little sunshine. Which causes the rooms to be damp. Also, in this area, people use fire-wood when they want to heat their rooms and this fire creates smoke which fills the rooms. Moreover, sweeping especially by women spreads dust throughout the house.

The majority of the local people keep livestock and domestic birds in the same house where they live. Women and children are often in contact with animals and collect animal faeces for drying with bare hands. They may not be sure whether they washed their hands or not, and subsequently start cooking or baking breads. All this life-style provides opportunities for the spreading of microbes and viruses.

For instance, the Qarabaghi village 7 km southwest of Espende, where 2500 families are living in an area of 6 km^2, is a very densely populated village. In each km^2 area

a total of about 416.67 families live. Often these houses are found to be very small and darken and even, animals are kept out of the houses, e.g. on the streets. Therefore the level of patients affected by different diseases, is higher than in any of the neighbouring villages.

According to the IAHC Ghazni Project Area Monitor & Assessment Report, children constitute 55.63 % of the families. In general the children are being breast-fed up to 2.5 years of age. After that children are fed with the common food taken by the family in that area. Children play outside in the streets with bare feet and sometime with only a shirt on. In the same dusty environment, children play and spend their time, without any attention from their parents. These children can run toward local products or fruits, buy and eat them on the spot

Children are cured, as mentioned before, by the old Greek, traditional and new medical methods. They are treated at home and if this gives no positive result, then it is the turn of tawiz or amulet. After this if there is no answer, then the patient is taken to a medical doctor. The patient often does not take a full dose of the medicine as after improving a little, the patient discontinues taking the pills and keeps them for a rainy day.

The position of women in Ghazni province before the 1978 coup was to some extent respected by men. Ghazni city had considerable effect on the surrounding villages. The women, from the villages near the city, and Kandahar-Kabul Highway, had stepped up to independence from the pressure of patriarchy. Whenever they became sick they could go to clinic or hospitals in Ghazni city or to Kabul for treatment. Another opportunity the women or girls had in the area, was to be married at an older age

Mirwais Khan's descendants expanded their influmnce until they occupied Iran's terretory upto Asfahan (1721).

After the collapse of the Afghan Government in Iran, an invasion was carried out by the Iranian Nadir Afshar, from Khorasan (1737) who reached as far as Kabul.

After a long struggle the major Pushtun tribes created a new Afghan state (1747). This is regarded as the start of the modern era.

The collateral descendants of Ahmad Shah (who established the new Afghan state) ruled over Afghanistan until the 1978' coup by pro-Soviet parties called Khalq and Parcham.

By 1839 the British army entered Afghasistan from three border points. They faced such resistance that the British army suffered one of the worst defeats it has ever suffered in the world. In 1978 the second Anglo-Afghan war took place. This time the war finished with definite defeat of the British army once again.

By January 1919 Afghanistan was affected by surr-ounding developments, and as a result , King Ammanullah came to power and declared an independent Afghanistan,free of external policy pressures.

Amir Ammanullah was overthrown by angry traditiona-lists and religious authorities, for his liberal reforms (1929). A Tajik rebel who led the uprising ruled for few months and then he was excecuted by king Mohd Nadir Shah.

By 1933 King Nadir Shah was assasinated by a left-wing student in Kabul.

From 1933 to 1973 King Zahir Shah ruled over the country. The country in his era was non-aligned in its foreign policy, with a rather conservative policy inside Afghanistan.

(e.g. >16 years), than was common in the past. But after the coup and subsequently the invasion and the rebellion of Afghans, the local women lost such social rights and became bound to stay in the four walls of their homes. They also lost the access to the health services and the marriage-age of the girls fell dramatically. Girls were even married at the age of ≤10 yrs. This condition also had an effect on the fertility rate of the women of the area. The public opinion about the position of women in society, which had been improved in favour of women, changed for the worse during the last 12 years of war. The female population became surrounded by an oppressed atmosphere, unaware of the rest of the world.

However after 1989, when IAHC employed a lady doctor graduated from Kabul Medical University, in its MCH programme, local people's respect toward women's medical services, increased. They (local people) still appreciate their work for them. As a result, out of 120 daily average patients of the clinic at Espende, 45 of them are women, The female patients include those pregnant women, who have their babies born in the MCH programme building.

Thus lack of information of the women about taking medicine, primary health principles and inadequate diet, increased their health problems. The diet of local women has no variety. Therefore a large number of mothers are suffering from food deficiencies and lack of vitamins in their bodies. The tremendous tragedies caused by war, has also threatened mothers' soul and psyches. This problem itself is a source of other diseaes for women. The obstacles which are built against female education, result in ignorance of women of health information and child care. Often mothers get infection from their children and in some cases children get infection from their mothers as well.

Comparing Ghazni Province with the neighbouring provinces, it is much better provided with education for young and old people. Education has been developing in Ghazni for the last 2 to 3 decades before the 1978 coup. Afterwards, the education process was halted. Only after 1985 a few educational facilities were provided by NGOs in which few girls in primary schools could be found. Health education is available in very limited sources.

Agriculture including irrigation has been severely damaged during the last 12 years of continuous war. People could not repair their destroyed dams, stream or karizes. It has affected directly the level of production of agricultural items such as wheat and vegetalbes. The food system of local people dropped by 80 percent. Poverty as a whole, malnutrition among children and anemia among mothers especially were the result of the destruction of the local cultivation. The orchards and forests were destroyed which has caused a change in the temperature as well as rise in the air pollution.

The local grasslands and meadows have become full of damger from buried mines. No animals are allowed to graze in the surrounding meadows, which has affected the nutrition of local animals. The explosion of mines however reduces the number of domestic animals which made their prices very high.

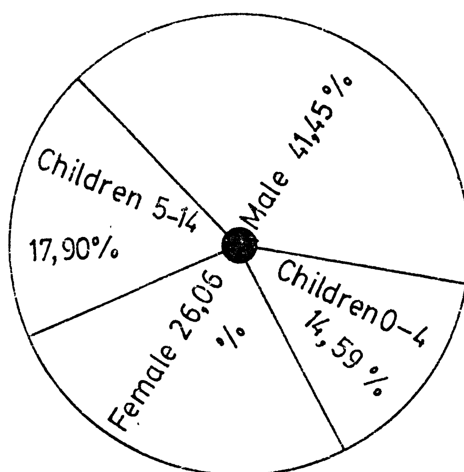
The 12 years of war made people in Ghazni very nervous and highstrung. Revenge and damaging pride can be found very often among Ghazni people.

Other sign of the war in area people, is the increasing desire for having more than one wife. This condition is apparently the result of killing or disability in many families. The common polygamy has raised the rate of the

local births. The high cost of a dowry has forced young men to immigrate and make money.

Following this description of the background of the area we will now present the data on the activities of the clinics in Ghazni, which have treated a total of 30151 patients, and its graph according to sex is shown on the nest page.

GHAZNI PROVINCE



Province: Ghazni .

District(s): Ghazni .

Year: 1990.

	MEN	%	WOMEN	%	CHILDREN, 0-4	%	CHILDREN, 5-14	%
Typhoid	2	0,02	3	0,04	5	0,11	10	0,18
Baciliary dysentery	115	0,92	19	0,24	253	5,75	208	3,84
Acute diarrhoea	400	3,20	280	3,56	1200	27,29	600	11,09
Amoebiasis, Giardiasis	240	1,92	107	1,36	153	3,48	258	4,77
Tuberculosis (all types)	10	0,08	13	0,16	8	0,18	4	0,07
Measles	—	—	—	—	26	0,50	2	0,04
Tetanus	—	—	3	0,04	1	0,02	—	—
Malaria	156	1,25	44	0,56	19	0,43	54	1.00
Intestinal worms	101	0,81	160	2,04	80	1,82	160	2,95
Scabies lice	13	0,10	5	0,06	—	—	2	0,03
Other infectious &Parasitic	173	1,38	71	0,90	99	2,25	142	2,62
Malnutrition: protein, calori	4	0,03	16	0,20	90	2,05	19	0,35
Goiter	8	0,06	—	—	—	—	—	—
Anemia	313	2,50	840	10,7	195	4,43	341	6,30
Nervous & Sensory disorders	18	0,14	12	0,15	—	—	—	—
Conjunctivitis	250	2,00	168	2,14	117	2,66	321	5,93
Trachoma	58	0,46	13	0,17	35	0,80	15	0,27
Otitis externa	48	0,38	3	0,04	26	0,59	11	0,20
Otitis media	119	0,95	130	1,66	374	8,51	260	4,80
Other nervous &sensory dis.	19	0,15	9	0,11	8	0,18	4	0,07
Hypertension	254	2,03	400	5,09	—	—	52	0,96
Other dis. of circulatory syst	217	1,73	150	1,98	6	0,13	2	0,03
Common cold, rhinitis URI	800	6,40	317	4,03	407	9,25	600	11,09
Tonsilitis (bact.)&pharyngitis.	300	2,40	61	0,77	188	4,20	353	6,52
Acute bronchitis	682	5,45	250	3,18	187	4,25	426	7,88
Pneumonia	172	1,37	100	1,27	30	0,68	113	2,09
Chronic bronchitis	230	1,84	250	3,18	—	—	22	0,40
Asthma	51	0,40	18	0,23	4	0,09	10	0,18
Other respiratory sys. dis.	115	0,92	89	1,13	120	2,73	95	1,76
Toothache, dental abscess	483	3,86	281	3,58	—	—	39	0,72
Gastritis, hearburn, indige.	847	6,78	332	4,23	28	0,63	65	1.2
Acute abdominal pain	42	0,33	15	0,19	4	0,09	17	0,31
Other dis. of digestive sy.	245	1,96	92	1,17	36	0,82	15	0,28
Cystitis & urinary tract in.	532	4,26	692	8,81	10	0,92	145	2,08
Renal colic	24	0,19	4	0,05	—	—	—	—
Vaginitis, Gonorhhea & PID	107	0,85	107	1,36	8	0,18	5	0,09
Menstual disorders	—	—	13	0,16	—	—	—	—
Other genitourinary disord.	34	0,27	107	1,36	38	0,86	16	0,29
Spontaneous abortion	—	—	39	0.5	—	—	—	—
Problems in pregnancy	—	—	91	1,16	—	—	—	—
Post-partum problems	—	—	71	0,90	—	—	—	—
Bacterial skin infection	288	1,82	147	1,87	91	2,07	212	3,92
Dermatitis & eczema	80	0,64	52	0,66	22	0,50	50	0,92
Other diseases of the skin	459	3,67	270	3,44	10	0,23	61	1,29

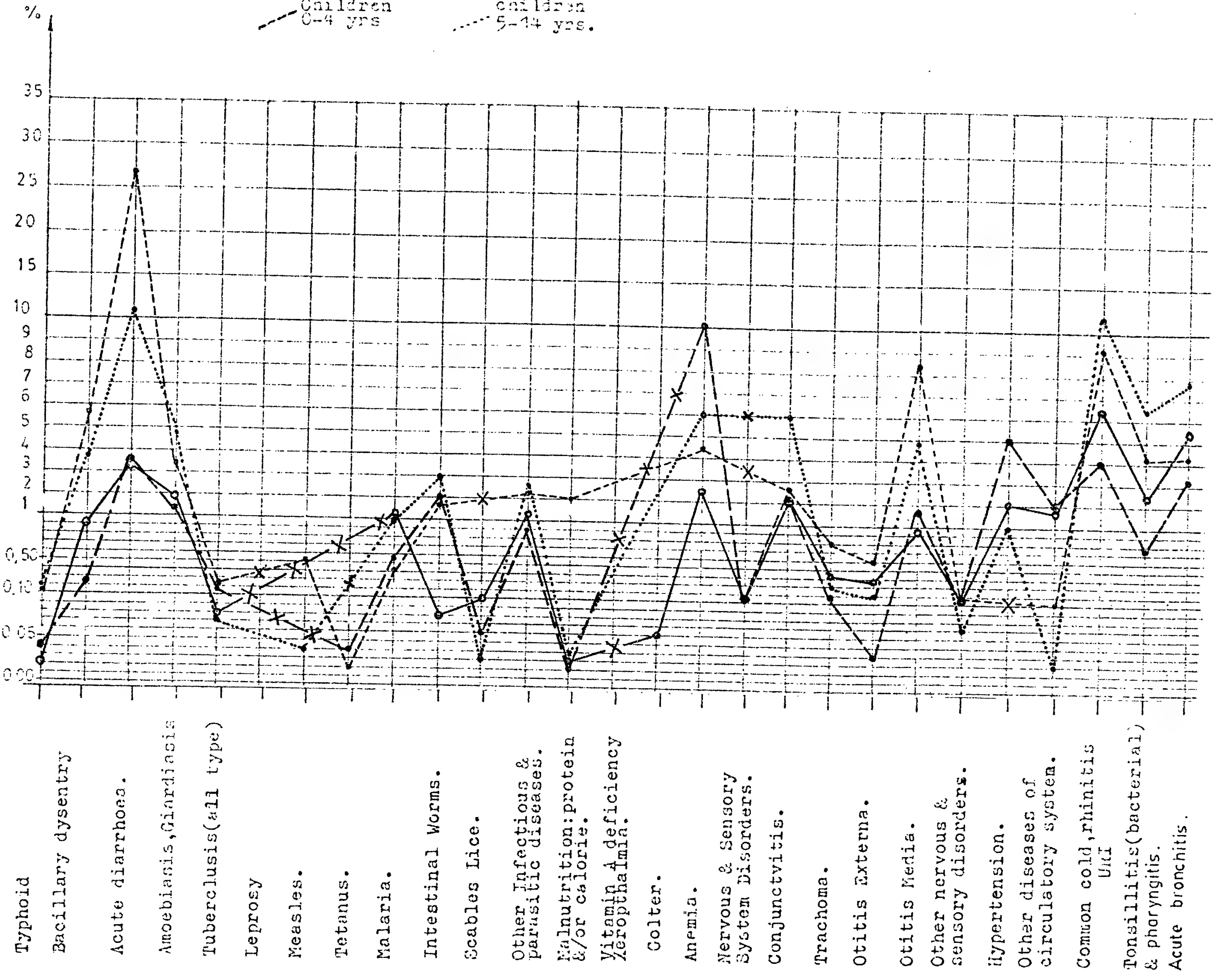
Medical Report By Group Diseases

Province: Ghazni.

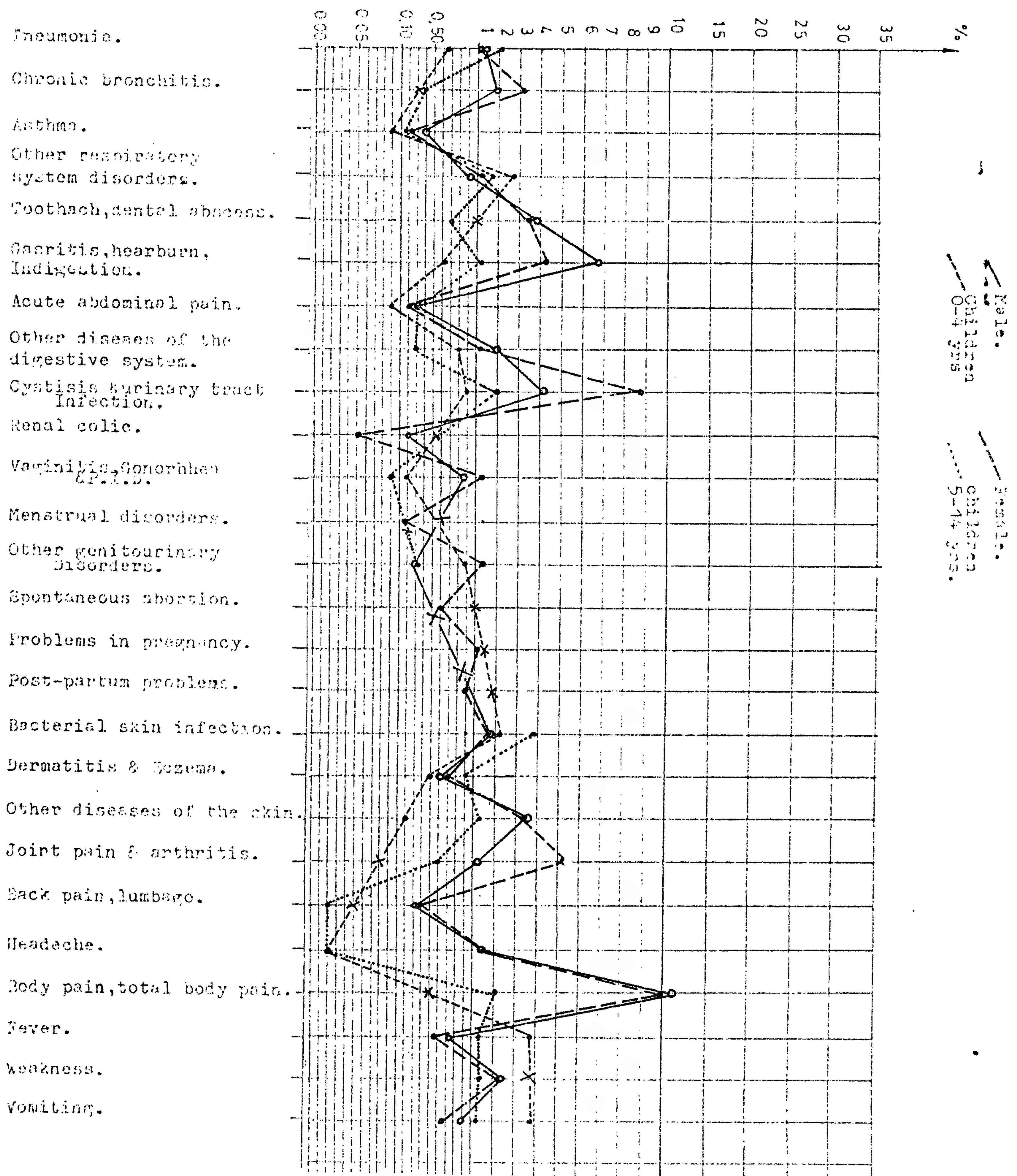
District(s): Ghazni.

Year: 1990.

	MEN	%	WOMEN	%	CHILDREN, 0-4	%	CHILDREN, 5-14	%
Joint pain & artritis	150	1,20	436	5,55	–	–	31	0,57
Backpain Lumbago	41	0,33	28	0,35	–	–	1	0,02
Headache	193	1,54	119	1,51	1	0,02	1	0,02
Bodypain total body pain	1519	12,16	783	9,97	–	–	114	2,11
Fever	98	0,78	43	0,55	169	3,84	72	1,33
Weakness	301	2,41	182	2,32	–	–	78	1,44
Vomiting	111	0,88	52	0,66	163	3,70	70	1,29
Other symptoms, signs, cond.	102	0,81	–	–	–	–	–	–
War trauma (battle)	24	0,19	15	0,19	–	–	5	0,09
Mine injuries	145	1,16	19	0,24	–	–	7	0,13
Non-war trauma	482	3,85	39	0.5	–	–	11	0.20
Burns	126	1,01	141	1,79	96	2,18	41	0,76
Other injury & poisoning	1293	10,34	153	1,95	90	2,05	266	4,92
Total	12494	41,45	7854	26,06	4397	14,59	5406	17,90
Acceptable error		-0,008 = 0,01		-0,005 = 0		-0,01		0.00
Drawing error		±0,07		±0,07		±0,07		±0,07
Total acceptable error		-0,01 -0,15		±0,07		+0,06 -0,08		±0,07

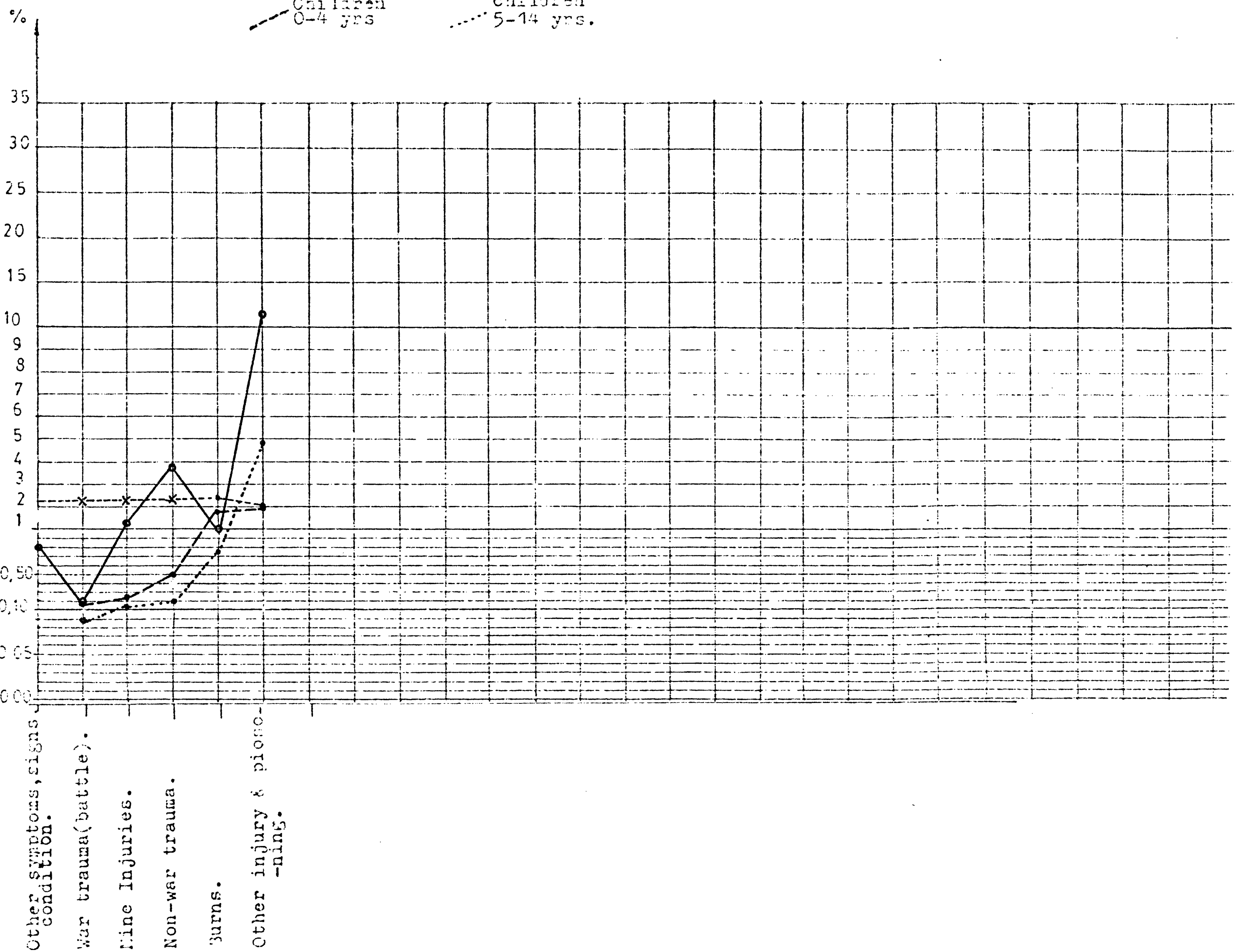


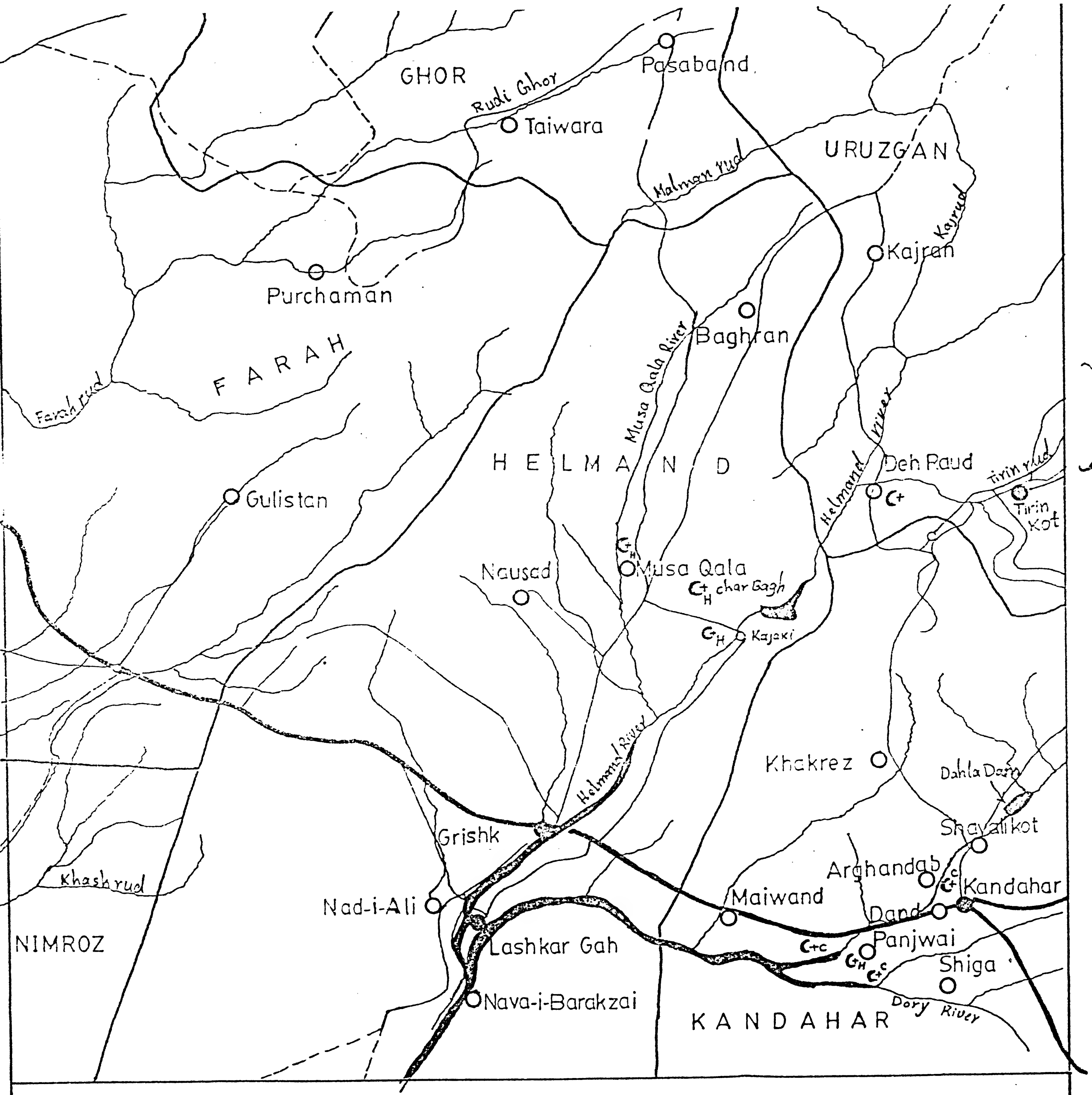
GHAZNI Province, Hakim-e-Sanai Central Polyclinic.
Male.
Female.
Children 0-4 yrs
children 5-14 yrs.
%
35
30
25
20
15
10
9
8
7
6
5
4
3
2
1
0,50
0,10
0.05
0.00
Typhoid
Bacillary dysentry
Acute diarrhoea.
Amoebiasis,Giardiasis
Tuberclusis(all type)
Leprosy
Measles.
Tetanus.
Malaria.
Intestinal Worms.
Scabies Lice.
Other Infectious & parasitic diseases.
Malnutrition:protein &/or calorie.
Vitamin A deficiency Xeropthalmia.
Colter.
Anemia.
Nervous & Sensory System Disorders.
Conjunctvitis.
Trachoma.
Otitis Externa.
Otitis Media.
Other nervous & sensory disorders.
Hypertension.
Other diseases of circulatory system.
Common cold,rhinitis URI
Tonsillitis(bacterial) & pharyngitis.
Acute bronchitis.



%
0.00
0.05
0.10
0.50
1
2
3
4
5
6
7
8
9
10
15
20
25
30
35
Pneumonia.
Chronic bronchitis.
Asthma.
Other respiratory system disorders.
Toothach,dental abscess.
Gastritis,hearburn, Indigestion.
Acute abdominal pain.
Other diseases of the digestive system.
Cystisis &urinary tract Infection.
Renal colic.
Vaginitis,Gonorhhea &P.I.D.
Menstrual disorders.
Other genitourinary Disorders.
Spontaneous abortion.
Problems in pregnancy.
Post-partum problems.
Bacterial skin infection.
Dermatitis & Eczema.
Other diseases of the skin.
Joint pain & arthritis.
Back pain,lumbago.
Headache.
Body pain,total body pain.
Fever.
Weakness.
Vomiting.
Male.
Female.
Children 0-4 yrs
Children 5-14 yrs.

GHAZNI Province, Hakim-e- Sanai Central Polyclinic.




GHOR
URUZGAN
FARAH
HELMAND
KANDAHAR
NIMROZ
Pasaband
Taiwara
Rudi Ghor
Malman rud
Kajran
Kajrud
Purchaman
Baghran
Musa Qala River
Farah rud
Deh Raud
Helmand River
Tirin rud
Tirin Kot
Gulistan
Nausad
Musa Qala
char Gagh
Kajaki
Khakrez
Dahla Dam
Shavalikot
Arghandab
Kandahar
Maiwand
Dand
Panjwai
Shiga
Dory River
Grishk
Khashrud
Nad-i-Ali
Lashkar Gah
Nava-i-Barakzai
Provincial Boundaries
Capitals
District Capitals
High way
Gravel way
Path way
River
Dam
Main River
IAHC Haspitals
Clinics
Map focused on Helmand province

Political crises both in Afghanistan and in the region did not allowed such goverment to survive any longer. This condition consequently brought about a bloodless coup within the King's family (July 1973) led by former prime minister Daud Khan.

M. Daud Khan, cousin of the ousted King, declared a Republican Afghanistan. He announced some minor reforms. Later he was approached by Soviet Block from the outside and surrounded by pro-Soviet cadres inside the parliament.

The steady and planned growth of Soviet interference eventually resulted in the April 1978 coup which brought about a puppet regime, backed directly by the Soviet Union.

This government led by Noor Mohd Taraki proclaimed radical reforms which provoked most of the Afghanistan's people. All Afghans considered the coup, the collapse of independence.

The strife caused by the government , could not be contained unless the Russian troops themselves entered Afghanistan (from the Russians' point of view) and this created one of the most chaotic periods in the history of the Afghan people.

By December 1979, 100,000 Russian troops invaded defenceless Afghanistan installing Babrak Karmal (pro-labour !!) as the leader of the People's Democratic Party of Afghanistan (PDPA).

From 1979 onwards, the Russians did not spare any means of killing, terror, disorder etc in order to make Afghans obedient to the Russian leadership.

As a reaction to such policy, a very fierce and powerful resistance or holly war (Jehad or Ghaza in Pushtu) formed among the Afghans, which finally led to exodus of over five million people and displacement of nearly three million inhabitants inside Afghanistan to more secure Places.

HELMAND:

IAHC Health Project in Helmand comprises of three hospitals and 21 dispensaries scattered over half of the Helmand area, Gulistan distriet of Frah Province, Tiwara area of Ghor Province and some parts of Oruzgan Province. The research which is carried out from Helmand Project includes only the three hospitals namely Kani-Manda, Char-Bagh and Kajaki.

In general, the hospitals are located in both flat and mountainous areas. The northern parts of the Mosa-Qala and Kajaki districts are mountainous while the neighbouring districts are lower and even. The Helmand province has a semi-tropical climate. Its summer is hot and dry, but other seasons have temperate and rainy weather. In summer the temperature rise to 42.5 C and in winter it fall down to - 0.9 C. The rainy season starts from the beginning of December up to the middle of the month of May. In July there are regional winds which cause rise in the temperature.

The general inclination of the area, starts as a long relief from north to south and southwest. The highest point in this province is 2000 m(Baghran) and the lowest point is in southern Helmand (Khwaja Ali) 692 m above the sea level. Most of the Helmand lands stretched in heights between 800 to 1200 meters above the sea level. Helmand has planty of water sources. No other province has such adequate and flowing water. The Arghandab and Helmand rivers pass through this province. Thus the northern Hel. has numerous karizes which from long ago only the Kajaki area had a total of 360 karizes.

The northern Helmand, where IAHC's hospitals are located, is the place for the Helmand, Mosa-Qala and Nowzad seasonal rivers to pass and intersect each other. The Mosa

Qala river in winter is often overflowing. Its water in summer is muddy. But in late summer, the river stops flowing and as a result swamps appear in different spots. These mires become the sources of the production of malarial mosquitoes. A good example is Toghai village near Mosa-Qala bazaar and this bazaar itself.

Thus the Helmand River has plantiful water during all the seasons. But in the spring and the beginning of April up to the middle of July the water level raise and overflowing its banks. Later the water level reduce and create mires along its banks. The same case is with Nowzad river.

The karizes waters also pass through villages and contaminate drinking water. Few wells are available in the area. Here most people use kariz and stream waters. The stream waters have often been muddy, especially when floods come down from the mountains and join the stream.

In general, the area which use IAHC health facilities has a dimension of 1660 km^2 and the population of the area is 95,770 person(Afghanistan Population, inside & outside 1990). A patient can reach any of the hospital from a 20 km distance within a day. But this figure is not adoptable with figure obtained from the area.Because northern Helmand (Toghai village as an example) has 3 to 3.5 % yearly average population growth. Even in some parts like Rabat in Kajaki and Regai in Mosa-Qala, because of higher rate of polygamy, the population growth raise to 7 percent a year.

Area people live generally in dark and small but shady rooms. As the summer is long in the area, houses are built shaded with small window-ed rooms and dome-shaped roofs. The majority of the families keep livestock and

birds in the same house they live. The house chores are completely done by female members. They burn fire-wood for cooking warming houses and other works like washing clothes. The fire-wood and animal excrement burning create bitter smokes in the rooms. The houses located along side the river and streams have moisture and are often under the threat of water. The kitchens are not kept from the dust. Often the cookings are performed in open space which dust and smokes make the dishes and food dirty. The rooms have no holes on the ceilings in order to send out the smokes and dusts.

Local' people major food comprises of wheat, maize vegetables and rarely meat and rice. The animal procuction such as milk, yoghurt, butter etc; and the grains or cereals are less used. Edible oil or ghee is used in large amounts. Bread is baked on metal plates with very hot fire, often burn the bread banks. Watery yoghurt is usually taken with bread.

Drinking water comes from karizes or streams which is often muddy. Except Nowzad, northern Helmand has little source of fruit. The only fruits they have, are mulberry, fig, appricot and apple.

A large number of people live as a family in one house. For example, in Regai village a family lived with 52 members. Also in winter, because of the high cost of house warming, a room is used by a large number of people. The children have also constituted the highest percentage of the families and make an average of 45.29 % of the population. No special protection in health exists for children. They drink the same muddy water and play with bare legs in the dust. They eat what family can provide for them. No immunization was common in the past in this area for the children. As a matter of fact, by 1989 some

organizations committed to vaccine the children.

Older children suffer from illeteracy and lack of good health services to meet all their needs. Among the children, the six kinds of diseases are being spread very quickly. In winter many victems are caused by measles and whooping cough. Deficient nutrition has also brought about malnutrition among children. Babies are usually fed however only by breast milk.

The local women pass an oppressed living system under the strong patriachy exists in the area. Old ladies and very young girls go to the clinics or purchasing something from the local bazaar. If women are ill, often the local health workers are going to their houses for treatment.

Considering this fact, IAHC regarded it necessary to establish a female clinic which will be soon completed. It will directly aim at the female treatment especially deliveries. According to 1991 research carried out by IAHC Mission, out of 100 TB patients, 59.18 were women. Lack of proper health care for women, raised problems in pregnancies and after births. As the food is not nutrient enough, thousands of females are becoming victims of several diseases; chiefly tuberculosis, anemia , and rheumatism. The ignorance of mothers have also contributed to the rise of diarrhoeal problems in the children. Takin medicine in improper way by women and children caused rise in the resistance of their bodies against the medicine.

Men are the only bread-winner in the family. Men are mainly working the land and produce the agricultural items. Others, involved in marketing as well as other jobs. They work hard. War pressures made them crude and rough. Area men are also suffering from different kinds of

diseases which are the result of the conditions of the 12 years war. Generally TB, Typhoid, Malaria and cholera have spread through out this area. As an example, in northeast Helmand especially Safid Hisar and Larkan Cholera is being spread from July to the middle of Sep.

Despite cultivation of opium and hashish, no addict of opium is found in the area. Even no one is habituated to the opium's extracts or residue. Snuff is the only thing local men are addicted of it.

Northern Helmand has no adequate fertile lands as to compare it with the population living in these areas. There are many families which have one jeribe or less than that. Because of air raid threats, farmers could not work the land properly. Besides, no one could take care of their karizes. Therefore thousands of acres of land remained uncultivated. The cultivation of cotton sustained heavy damage after the war. The agricultural products level fall down unprecedently. The livestock business has thus remarkably collapsed. The pollution of pasture lands caused rise in the death of thousands of domestic animals. These animals are sacrificed at the markets and altimately sold. This condition contribute to the spreading of different kinds of diseases among local residents.

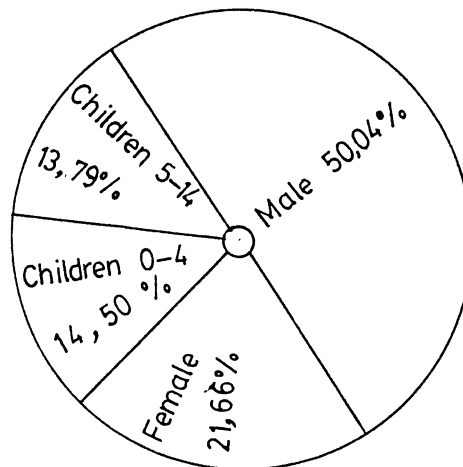
Education exists at a lower level. Many educated individuals left the area. The destruction of schools within war time has eventually affected especially the health situation of the local people. No attention is paid to the importance of primary health care.

People believe in taking strong medicine available in the local bazaars. This itself caused several health problems.

The education primarily exists for male children only. But in the recent years some NGOs have been trying to form a standard of new educational system in order to improve the literacy level in the area.

Coming to final words, by 1990 the three IAHC hospitals have treated 56259 patients. The local dispensaries figures arenot included in our research. On the next page, the graph of the patients and percentage with sex is presented for your information.

HELMAND PROVINCE

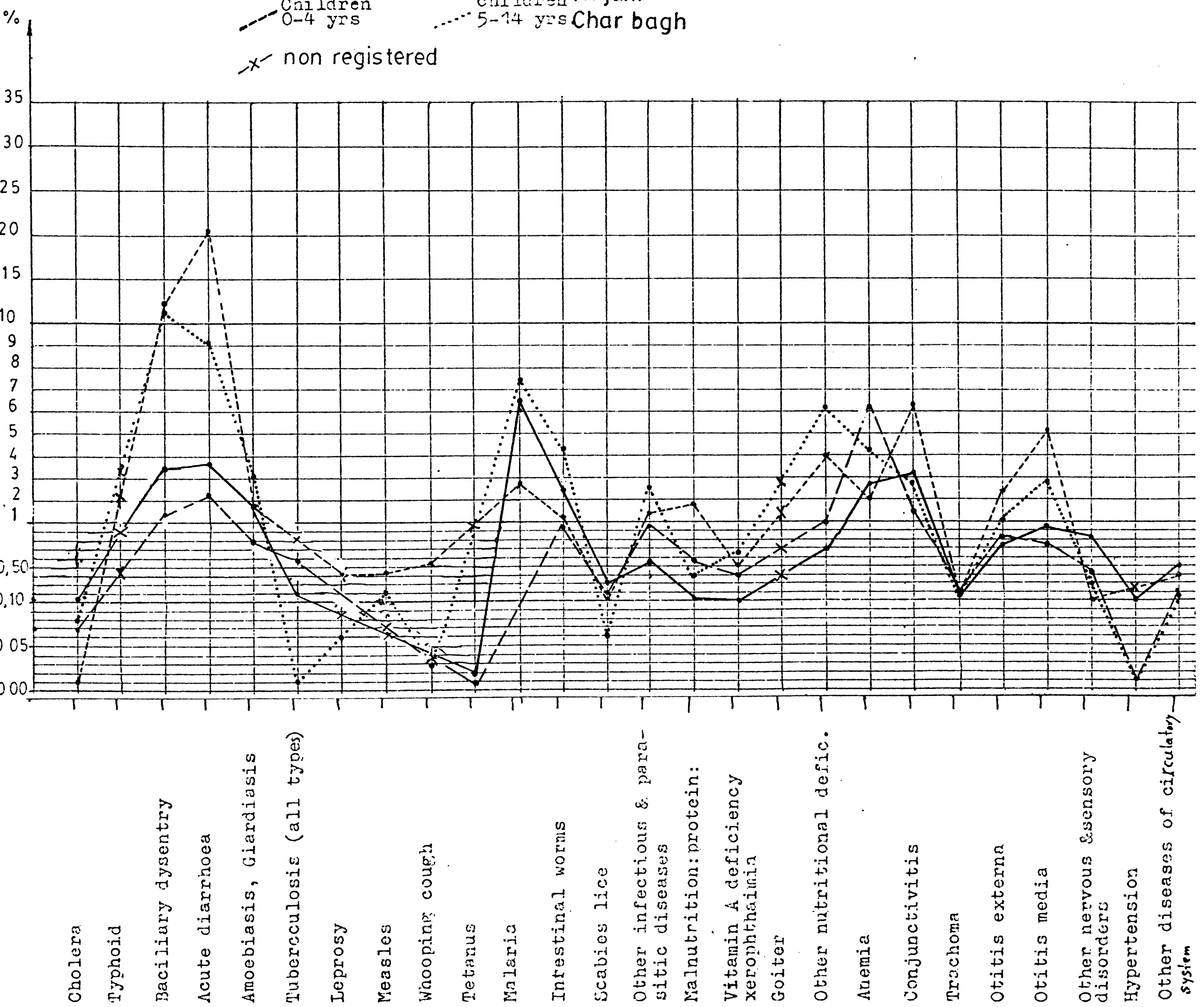


Province: Helmand .

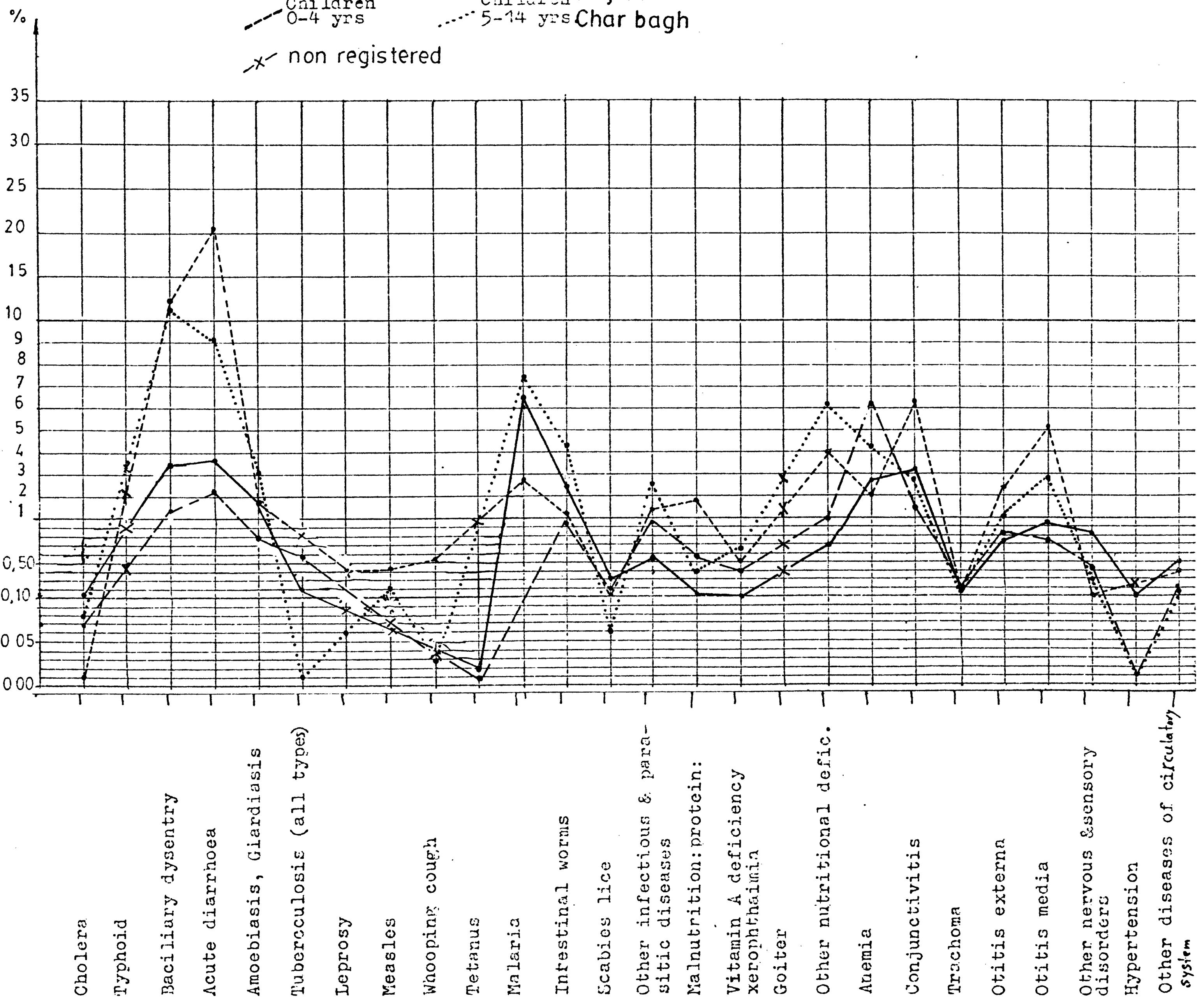
District(s): Mosa-Qala, Kajaki .

Year: 1990.

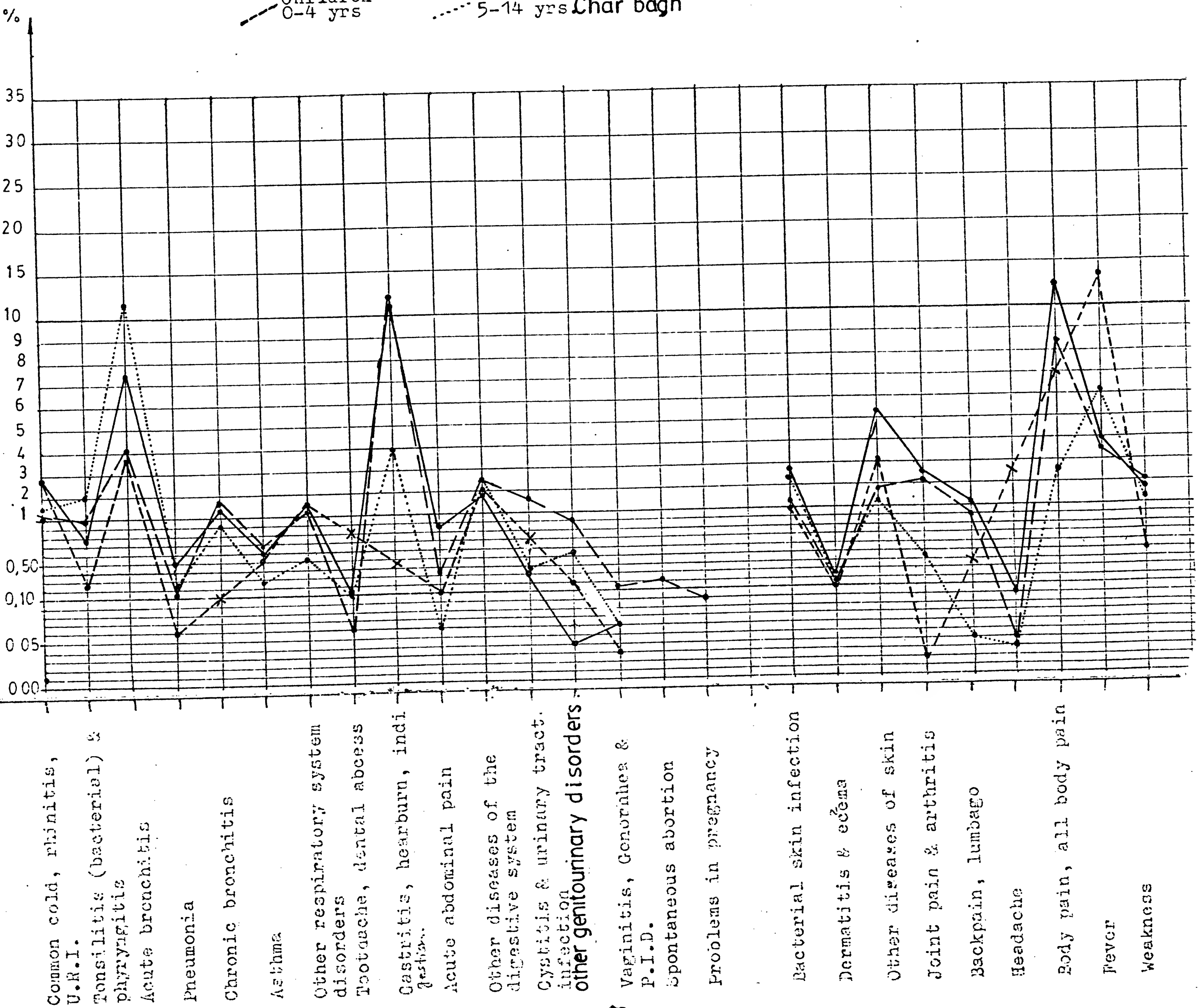
	MEN	%	WOMEN	%	CHILDREN, 0-4	%	CHILDREN, 5-14	%
Cholera	42	0,15	9	0,07	3	0,01	6	0,08
Baciliary dysentery	993	3,53	160	1.31	1000	12.24	900	11,60
Acute diarrhoea	1004	3.58	276	2.26	1754	21,50	712	9.18
Amoebiasis, Giardiasis	500	1.78	100	0,81	150	1.82	234	3,02
Tuberculosis (all types)	49	0,18	71	0,58	–	–	1	0,01
Leprosy	–	–	–	–	38	0,45	5	0,06
Measles	–	–	–	–	45	0,54	15	0,19
Whooping cough	–	–	–	–	20	0,23	2	0,03
Tetanus	5	0,02	2	0,01	–	–	–	–
Malaria	1831	6,52	778	6.41	233	2,84	581	7.49
Intestinal worms	681	2.42	115	0,94	92	1.11	337	4.34
Scabies lice	86	0.31	26	0,20	11	0,13	5	0,06
Other infectious &parasitic	154	0,55	118	0,95	113	1,37	198	2,55
Malnutrition: protein	30	0,11	70	0,57	151	1,83	30	0.39
Vitamin A deficiency xeroph	29	0,10	49	0,39	42	0,50	51	0,66
Other nutritional deficiency	191	0,68	121	0,99	325	3,97	480	6,19
Anemia	766	2,73	823	6,18	169	2,06	329	4,24
Conjunctivitis	899	3,20	173	1.42	514	6,29	220	2,84
Trachoma	43	0,15	28	0,22	13	0,14	10	0,13
Otitis externa	209	0,74	100	0,81	196	2,39	84	1,08
Otitis media	261	0,93	91	0,74	419	5,11	222	2,86
Other nervous &sensory dis.	232	0,83	53	0,43	9	0,10	21	0,27
Hypertension	31	0,11	3	0,01	—	—	1	0,01
Other diseases of circulat.	146	0,52	27	0,20	33	0,40	14	0,18
Common cold, rhinitis URI	780	2,78	123	1,00	234	2,86	101	1.30
Tonsilitis (bac.)& pharyng.	2061	7.33	500	4,10	307	3,75	881	11.35
Acute bronchitis	215	0,77	120	0,98	21	0,25	148	1,91
Pneumonia	135	0,48	17	0,13	6	0,06	15	0,19
Chronic bronchitis	350	1,25	178	1,43	–	–	70	0,90
Asthma	164	0,58	78	0,63	43	0,52	19	0,24
Other respiratory sys. dis.	453	1,61	153	1,25	94	1,14	40	0,52
Toothache, dental abscess	30	0,11	8	0,06	–	–	8	0,10
Gastritis, hearburn, indiges.	3078	10,95	1433	11,87	–	–	306	3,94
Acute abdominal pain	243	0,86	41	0,33	9	0,10	5	0,06
Other diseases of digestive sys.	522	1.86	231	2,64	160	1.96	190	2,45
Cystitis &urinary tract inf	82	0,29	195	1,60	–	–	35	0,45
Vaginitis, Gonorhhea & PID	18	0,06	18	0,14	2	0,03	5	0,06
Other genitourinary disorders.	11	0,04	110	0,90	20	0,23	50	0,64
Spontaneous abortion	—	–	25	0,20	—	–	—	—
Problems in pregnancy	–	–	12	0,09	–	–	–	–
Bacterial skin infection	796	2,83	162	1.33	86	1,04	202	2,60
Dermatitis & eczema	71	0,25	23	0,18	10	0,12	20	0.26
Other diseases of the skin	1493	5,32	224	1.84	270	3.30	116	1,48



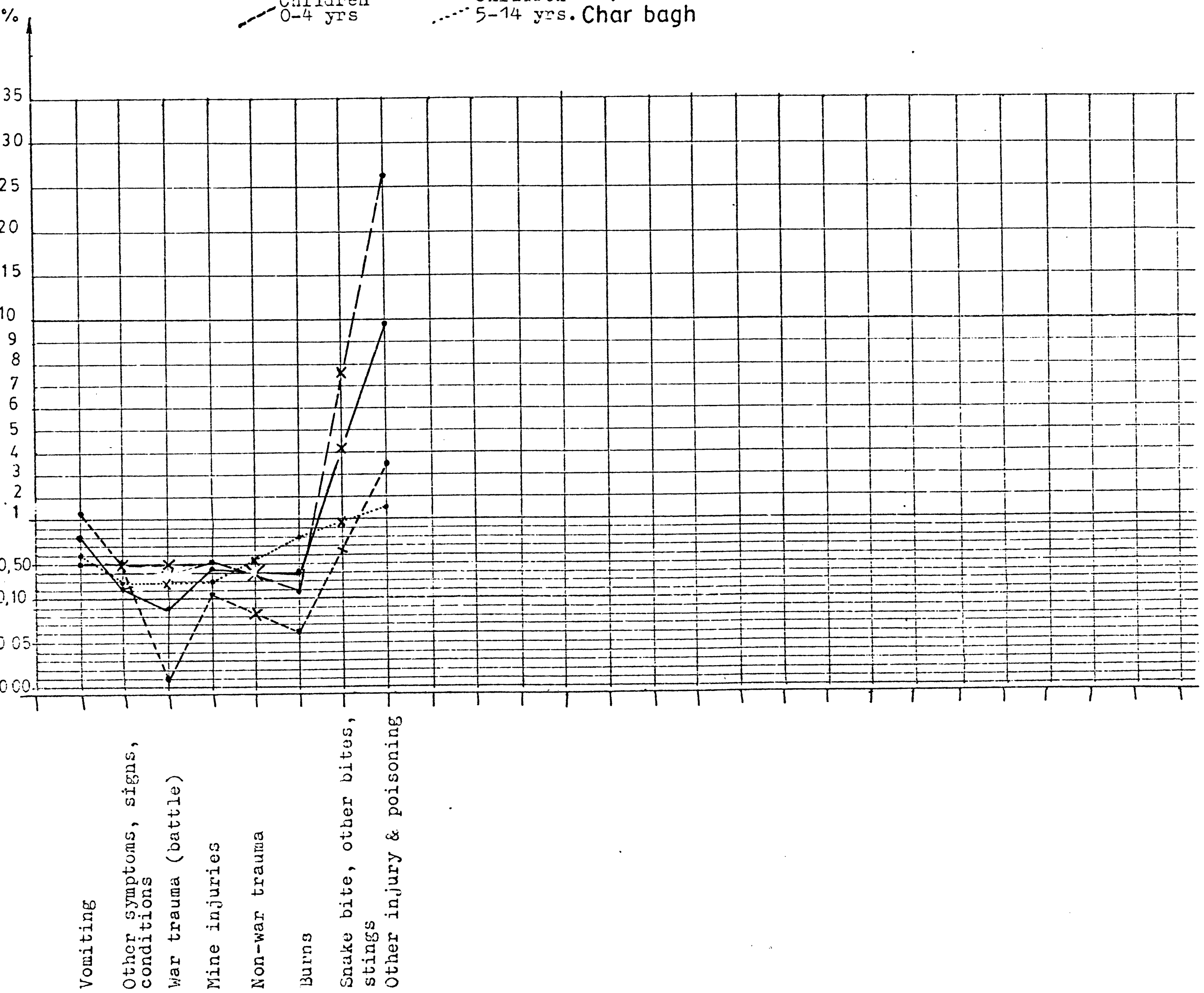
HELMAND Province,
Hospital/ clinic
Male.
Female.
Mosa qala
Children 0-4 yrs
children 5-14 yrs
Kajaki
Char bagh
non registered
%
35
30
25
20
15
10
9
8
7
6
5
4
3
2
1
0,50
0,10
0 05
0.00
Cholera
Typhoid
Baciliary dysentry
Acute diarrhoea
Amoebiasis, Giardiasis
Tuberculosis (all types)
Leprosy
Measles
Whooping cough
Tetanus
Malaria
Intestinal worms
Scabies lice
Other infectious & parasitic diseases
Malnutrition: protein:
Vitamin A deficiency xerophthalmia
Goiter
Other nutritional defic.
Anemia
Conjunctivitis
Trachoma
Otitis externa
Otitis media
Other nervous &sensory disorders
Hypertension
Other diseases of circulatory system


HELMAND Province,
Hospital/ clinic
Male.
Female.
Mosa qala
Children 0-4 yrs
children 5-14 yrs
Kajaki
Char bagh
non registered
%
35
30
25
20
15
10
9
8
7
6
5
4
3
2
1
0,50
0,10
0 05
0 00
Cholera
Typhoid
Bacillary dysentry
Acute diarrhoea
Amoebiasis, Giardiasis
Tuberculosis (all types)
Leprosy
Measles
Whooping cough
Tetanus
Malaria
Intestinal worms
Scabies lice
Other infectious & parasitic diseases
Malnutrition: protein:
Vitamin A deficiency xerophthalmia
Goiter
Other nutritional defic.
Anemia
Conjunctivitis
Trachoma
Otitis externa
Otitis media
Other nervous &sensory disorders
Hypertension
Other diseases of circulatory system

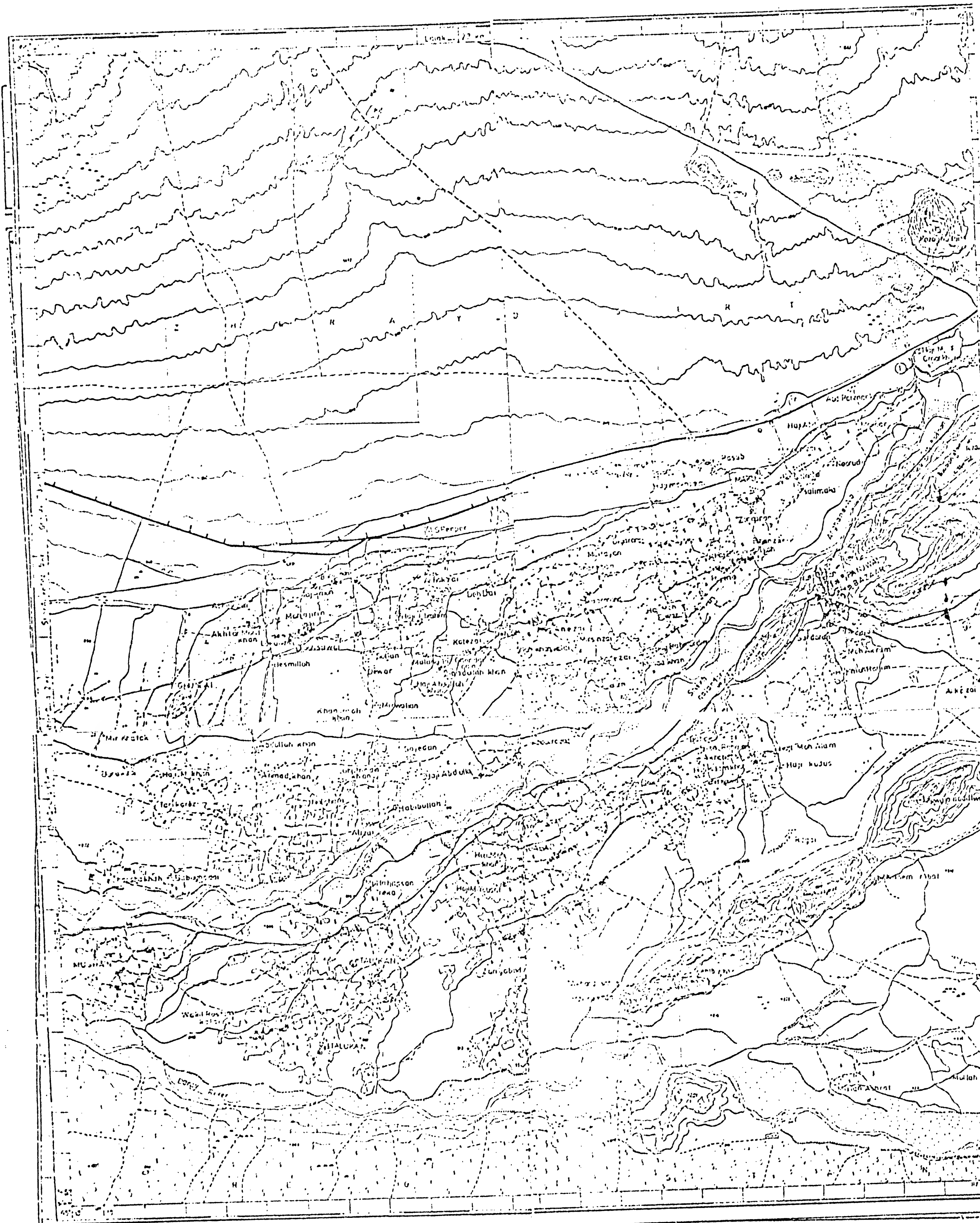
Let us hope for a lasting solution to the crisis and a peaceful Afghanistan once again, and try to rehabilitate this war torn country people tired of war, as quickly as possible.



HELMAND Province,
Hospital/ clinic
Male.
Female.
Mosa qala
Children 0-4 yrs
children 5-14 yrs
Kajaki
Char bagh
%
35
30
25
20
15
10
9
8
7
6
5
4
3
2
1
0,50
0,10
0 05
0 00
Common cold, rhinitis, U.R.I.
Tonsilitis (bacterial) & phyryngitis
Acute bronchitis
Pneumonia
Chronic bronchitis
Asthma
Other respiratory system disorders
Toothache, dental abcess
Gastritis, hearburn, indigestion
Acute abdominal pain
Other diseases of the digestive system
Cystitis & urinary tract infection
other genitourinary disorders
Vaginitis, Gonorrhea & P.I.D.
Spontaneous abortion
Problems in pregnancy
Bacterial skin infection
Dermatitis & ecžema
Other diseases of skin
Joint pain & arthritis
Backpain, lumbago
Headache
Body pain, all body pain
Fever
Weakness



HELMAND Province,
Hospital/ clinic
Male.
Female.
Mosaqala
Children 0-4 yrs
children 5-14 yrs.
Kajaki
Char bagh
%
35
30
25
20
15
10
9
8
7
6
5
4
3
2
1
0,50
0,10
0 05
0 00
Vomiting
Other symptoms, signs, conditions
War trauma (battle)
Mine injuries
Non-war trauma
Burns
Snake bite, other bites, stings
Other injury & poisoning



SCALE 1:50000

0 0.5 1 1.5 2 km

500 Meters in 1Cm

LEGEND

- High way
- Gravel Way
- Road
- Path
- Bazaar and Village
- Home
- Ravine
- River
- Canal
- Sewer

Abd - Abdul

Moh,M - Muhammad

- Shrine
- Fissure
- Graphs Horticulture Lands
- Crops Cultivation Lands

(1) Area under stress of water

Kandahar province
Panjwai bazaar

ISLAMIC AID HEALTH CENTER	
Owner of IAHC	Dr. A.B. Hagani
Assistant Supervisor	Eng. M. Rabi Amaf
Preparation Date	16-03-1990

KANDAHAR

In Kandahar Province up to 1990 IAHC had four clinics which are located in Arghistan, Panjwai Bazaar, Tolokan and Sangesar areas. People daily visit the clinic in each district from an average distance of 20 km. The Panjwai and Maiwand districts have 6086 km^2 and Arghistan 2513 km^2 residential areas from where the patients come to visit the clinics. These areas are in addition to those areas from which patients travel more than one day to come to the clinic.

The Kandahar Province is being mainly irrigated by the three (Arghistan, Arghandab and Keshke-Nakhud) rivers. It's weather is similar to Helmand's e.g. sub-tropical with hot summers and temperate rainy seasons of authumn, winter and spring. There are rains from December up to the middle of May. The temperature in winter reaches to (-1.5 °C) and in summer it rises to 40 °C. Mild winds which blow from east to west changes the temperature. The wind's direction also changes sometimes and brings clouds and rains over the area. In the desert areas of Daman, Maiwand Kandahar air-port down up to Chaman there is wind that is called cyclonic and often blows in mid-days. The wind increase in speed especially where there are no trees and water. Often dust is taken with the wind up to 1.5 km , even in the areas close to the sandy zones, 1.5 mm layer of soil is being swept with the wind. The dust reaches to the Kandahar city and pollutes the air.

As mentioned before, the three rivers irrigate most of Kandahar's lands. The water of Arghistan and one of its tributaries (Tarnak) is salty and muddy. These waters when they join each other called Doray, which is seasonal river is usually flowing with muddy water.

The Arghistan river itself is always full of water. This is why there are no mires along its banks. In this area people dig a draining place and lead the water from mountain slopes to gather in it. Then people use this callected water in the summer. This also becomes contaminated.

The Doray river, south of Panjwai, meanders along with a slope of 1 percent. In some parts the meandering causes swamps especially by Arghandab river from Panjwai Bazaar to Moshan area. Then to the north of Arghandab river, the meandering creates mires in Safid Rawan and Qulf-o-Salwaghai areas. The best place for mosquitoes to lay eggs are these mire, especially in Kandahar area sand-fly is very health-threatening. These sand-flies had been in Kandahar from long ago.

Northern partsoof Maiwand district also use kariz water for agricultural and domestic purposes. Kariz waters are used over a long distance. But here the water is not as contaminated as it is in Ghazni. The reason behind it is that this area is not densely populated. Therefore the level of water contamination is less. The area using kariz water are Maiwand district, south and south west of Dand (Regwa), Mola-Dost, Mola Ashrat and Nakhoni.

People in rural Kandahar generally live in sheddy houses with narrow and small windows. The rooms are made with high and dome-shaped ceilings. The floors are often not filled and so they are wet. Such dark rooms are suitable places for sand-flies. The windows have no nets for preventing the insects to enter the rooms. In the summers because of the hot weather, people sleep during the middle of the day in underground rooms. It had been the tradition among local people to splash or spray water where (veranda or the gardens) they sit to prevent the dust especially in the

evening time. Spraying water also increases moisture. In the rural areas people spread local bushes called Munj, on the floor, especially in guest rooms.

The local diet consists of potatoes, vegetables, okra, aubergene, rice meat, watery yoghurt and other things. In cooking they frequently fry or toast onion and grape - vinegar is often used in meal. Domestic animal products are also used here. Wheat is the most consumed item in the local food.

The household affairs are always performed by women. Taking care of children, cooking, cleaning and other care. The local women have more or less similar living condition to the rest of Afghanistan. Women in old age & young girls often come to the clinics. The education level among them is unsatisfactory. Children are cared for and protected as in Helmand. Most of the time, the children are in contact with their mothers or sisters. Children are fed with the common food the family takes. They play in the yards or streets that is a very dusty environment. The same Greek and traditional medical method of treatment is used here, and if the amulet does not work, the local people will go to the accessable clinic.

Among children, because of lack of primary health care , the diarrheoal diseases are the most common as are eye infections and skin infections which are all caused by either polluted surrounding , fruits without being washed, or drinking uncleaned water.

As is very common, the marriage age is very low. Not only are girls married at a younger age, but several closely spaced births are also common. This way of life and and social pressures cause many different diseases among women. The most commonly problems in females, are TB, anemia, rheumatism, gastritis and psycological and neural

problems. The 12 years war has also contributed its share. It's important to mention that a problem called Destone-neuro-vigitative (IAHC Panjwai & Maiwand Survey Report, Kandahar, 1990) caused by war pressures, has increased among young people. As the intensity of war declined the number of patients suffering apparently lessened.

Lack of variety of food and high cost of most of the items, caused several food defeciencies to emerge among local people.

The Kandahar health facilities provided a good service for the neighbouring rural population. This connection was cut after the war started. The effects of proximity to Kandahar city on education and other cultural affairs of the surrounding areas were sinificant. This situation has also been affected. Most of the rural population especially men have been deprived from these educational and health facilities. The male students were involved in fighting, some others went to mosques for the religious teachings in traditional way. Upto now no health education was common in the area. Recently the active NGOs plan to conduct health education via the MLHWs through the clinics.

Vaccination, except in Kandahar city, has not taken place in the whole province.for many years. Only in the recent years some NGOs started to vaccine women and children.

The mentioned existing conditions all together contributed to the rise of several health problems. Many NGOs' introduced health facilities with large amount of medicine which has caused the local population to abuse medication . For more information, please refer to the IAHC Panjwai & Maiwand District Survey Report Jan-Feb 1990.

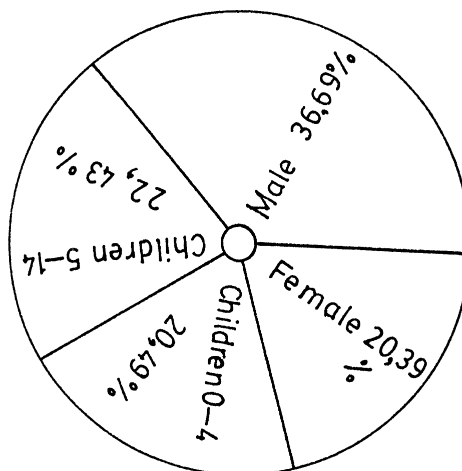
Thus Kandahar Province especially in districts such

as Arghandab, Panjwai, Dand and Maiwand is a very densely cultivated area. The role of orchards and vineyards had been very important in air filtration. But unfortunately the destruction of orchards by countless bombings affected indirectly the health of local people. The poisonous gases and smokes have polluted the trees and bushes.

In Kandahar generally animals are kept to meet the household needs. For business, livestock is kept in Ghorak, Khakriz, Reg and Daman areas. The reduction in the number of domestic animals has also partly contributed to the food deficiency of the local population.

Following the above description of the current situation in this area, we will now present the data on the activities of the IAHC clinics in 1990, which have treated a total of 31503 patients. Please find the graph on the next page.

KANDAHAR PROVINCE



Medical Report By Group Diseases

Province: Kandahar

District(s): Panjwai, Maiwand, Arghistan

Year: 1990

	MEN	%	WOMEN	%	CHILDREN, 0-4	%	CHILDREN, 5-14	%
Cholera	1	0,01	—	—	—	—	—	—
Baciliary dysentery	430	3.72	310	4,82	770	11,93	570	8,06
Acute diarrhoea	340	2,94	260	4,05	1020	15,80	770	10,88
Amoebiasis, Giardiasis	190	1.64	170	2,65	220	3,41	320	4,53
Tuberculosis (all types)	—	—	—	—	—	—	—	—
Measles	—	—	—	—	30	0,46	9	0,13
Tetanus	8	0,07	—	—	—	—	—	—
Malaria	737	6.38	406	6.32	330	5.11	768	10,87
Intestinal worms	29	0,25	51	0,79	150	2,32	280	3,95
Scabies Lice	107	0,92	33	0,51	40	0,62	16	0,23
Other infectious &parasitic	83	0,72	34	0,53	100	1,55	60	0,85
Malnutrition: protein	10	0,08	54	0,35	85	1,32	15	0,21
Other nutritional deficien.	5	0,04	10	0,15	35	0,54	15	0,21
Anemia	300	2,59	700	10,89	400	6,20	500	7,07
Conjunctivitis	257	2,22	146	2,27	317	4,91	354	5,01
Trachoma	62	0,53	21	0,33	36	0,56	16	0,22
Otitis externa	30	0,26	20	0,31	35	0,53	61	0,86
Otitis media	202	1,75	180	2,80	830	12,85	355	5,02
Other nervous &sensory diso.	146	1,26	35	0,54	16	0,25	7	0,10
Hypertension	33	0,28	22	0,34	—	—	4	0,05
Other diseases of circulatory sys.	22	0,19	16	0,25	4	0,06	1	0,01
Common cold, rhinitis URI	917	7.93	354	5,51	398	6,16	593	8,39
Tonsilitis (bact.)&pharyngitis.	148	1,28	131	2,04	141	2,18	329	4,65
Acute bronchitis	759	6,57	264	4,11	217	3.36	531	7,51
Pneumonia	250	2,16	88	1.37	40	0,62	70	0,99
Chronic bronchitis	300	2,59	200	3,11	—	—	20	0,28
Asthma	58	0,50	39	0.61	22	0,34	30	0.42
Other respiratory system disor	242	2,09	80	1.24	143	2,21	61	0.86
Toothache dental abscess	397	3.44	129	2,00	—	—	86	1,21
Gastritis, hearburn, indigestion.	1563	13.52	564	8.78	137	2,12	57	0,80
Acute abdominal pain	96	0.83	23	0,36	34	0,53	14	0,20
Other diseases of diges sys	380	3,29	120	1,87	136	2,11	58	0,87
Cystitis &urinary tract inf	110	0.95	141	2,19	18	0,28	30	0,42
Renal colic	69	0,60	20	0,31	—	—	—	—
Vaginitis, Gonorhhea & PID	—	—	258	4,01	2	0,03	1	0,01
Menstrual disorders	16	0,14	64	1,00	—	—	19	0,27
Other genitourinary disord.								
Spontaneous abortion	—	—	38	0,58	—	—	—	—
Problems in pregnancy	—	—	7	0,11	—	—	—	—
Bacterial skin infection	410	3,55	183	2,85	59	0,91	454	6.42
Dermatitis & eczema	48	0,41	21	0,32	16	0,25	38	0,53
Other dis. of the skin	323	2,79	227	3,53	80	1,24	191	2,70

POPULATION STATISTICS :

The population of Afghanistan by the end of 1970s was 15.5 million people. Today the population including the refugees outside amount to 19,136,000 (a 2.4 % increase which is thought to be the most likely population growth in Afghanistan, extrapolated from 1979,,from the existing population census), (UNHCR report Geneva, June 1988).

According to the Kabul government statistics (1974) every year about 300,000 people are added to the population (Annual Report Kabul Government 1974).

The invasion of Russian troops resulted in the exodus of the world's largest number of refugees (2/5 of the total refugees through out the world), (UNHCR 1988).

According to UNHCR statistics, there are 3,271,304 Afghans (445,796 families) who have taken refuge in Pakistan, 2,200,000 fled to Iran, of which some are in the Western countries.

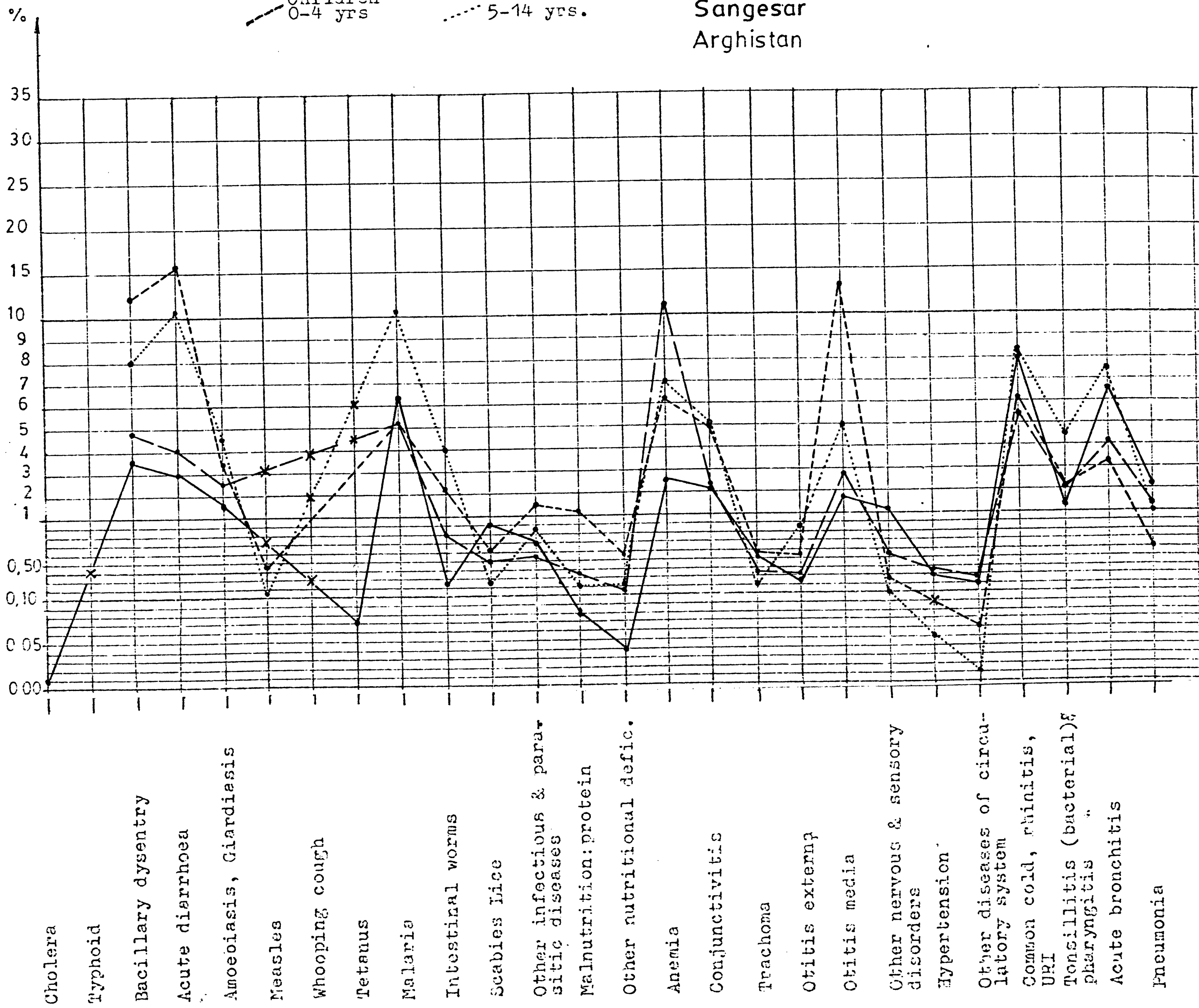
During the last 12 years of war almost half of the population of Afghanistan has been uprooted. The population in Kabul city is rapidly increasing . It is reported to have grown to 3,000,000 people (UNOCA 1988).

Province: Kandahar

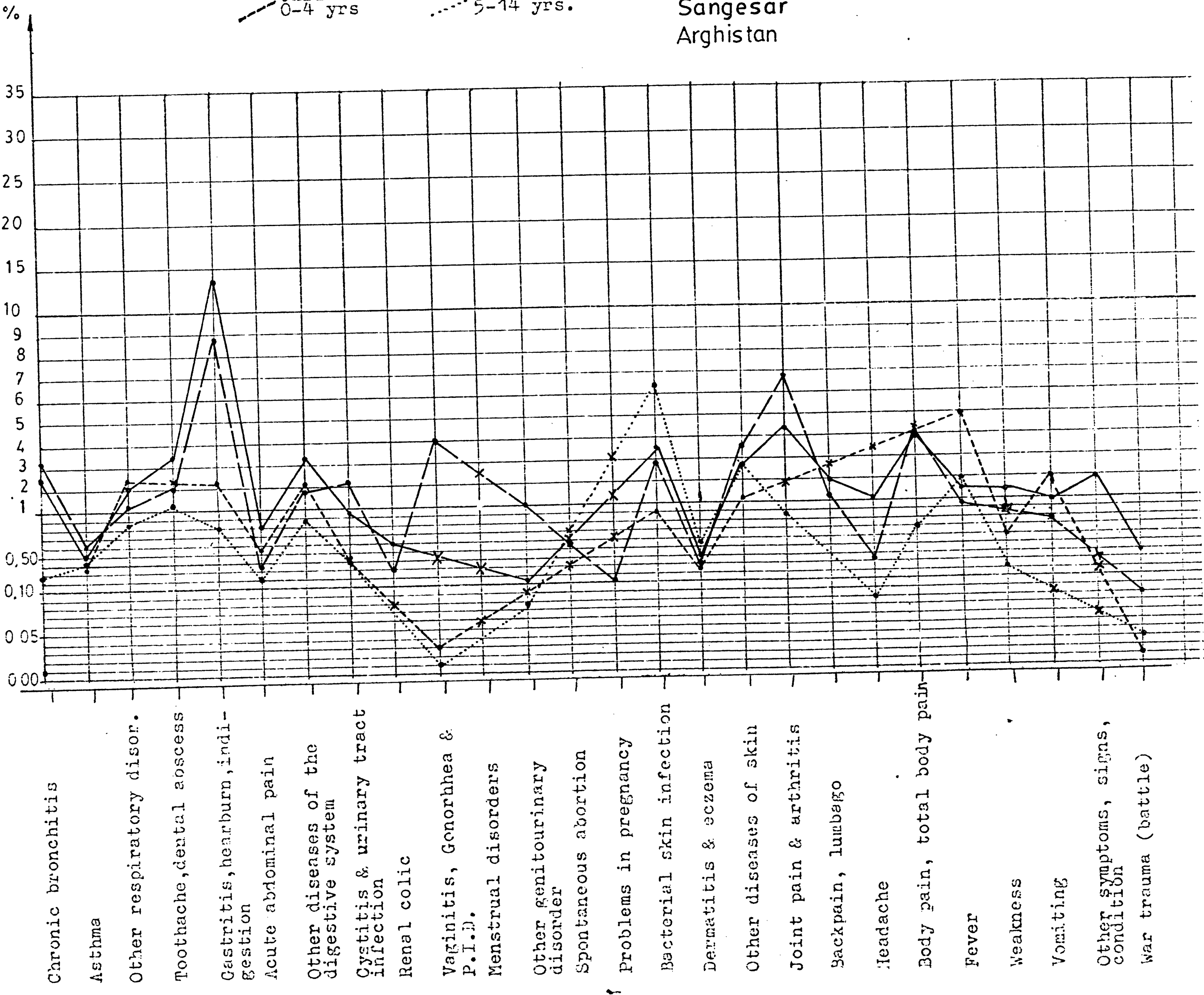
District(s): Panjwai, Maiwand, Arghistan.

Year: 1990

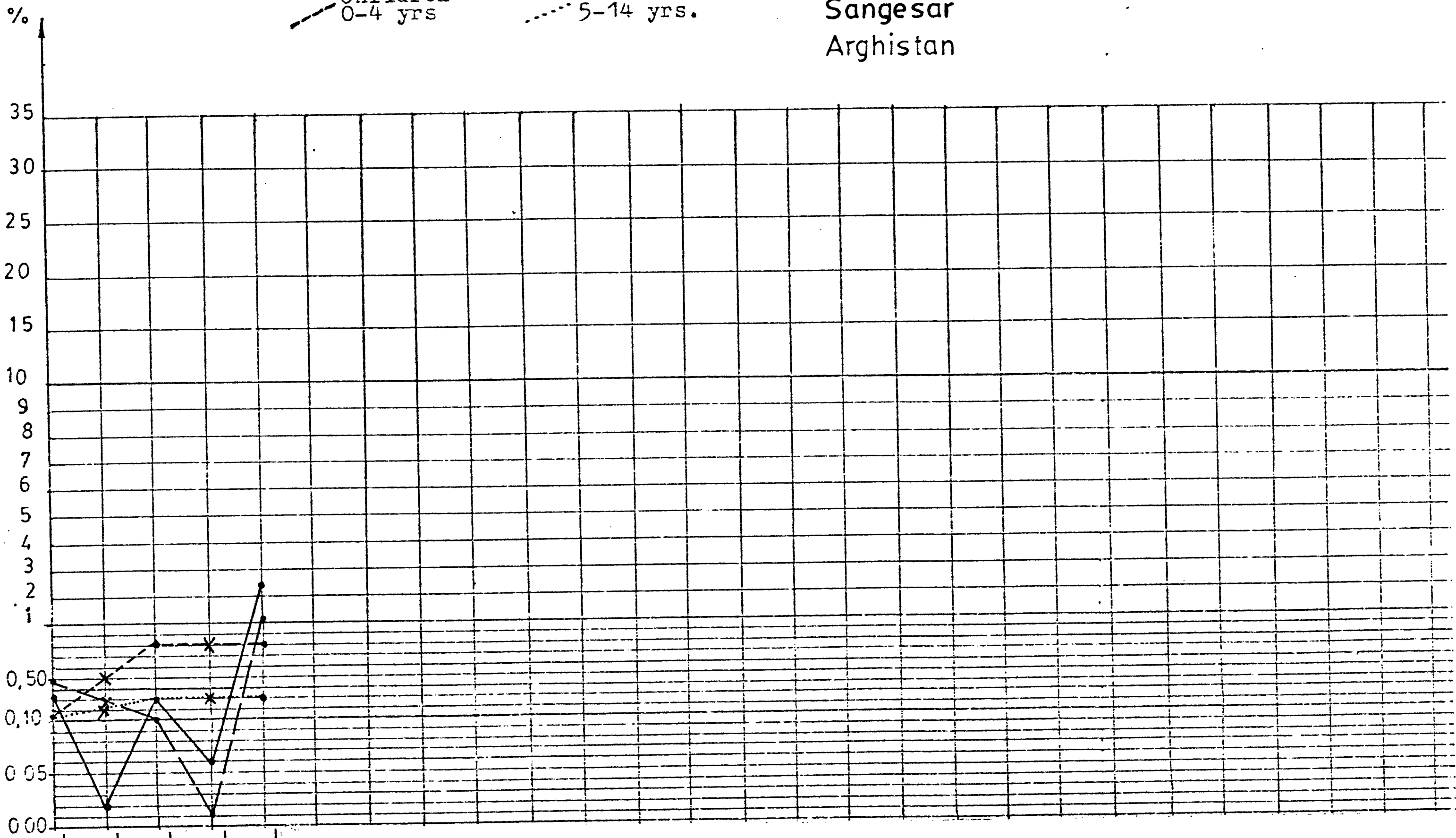
	MEN	%	WOMEN	%	CHILDREN, 0–4	%	CHILDREN, 5–14	%
Joint pain & arthritis	507	4,39	435	6.77	–	–	60	0,85
Backpain, lumbago	221	1,91	77	1.20	–	–	–	–
Headache	129	1,11	21	0,33	–	–	6	0,08
Bodypain, total body pain	458	3,96	264	4,11	–	–	50	0,70
Fever	178	1.54	61	0,95	318	4,93	136	1,92
Weakness	173	1.49	–	–	38	0,59	16	0,22
Vomiting	125	1,08	50	0,78	127	1,97	55	0,77
Other symptoms, signs, conditions.	223	1,93	–	–	–	–	–	–
War trauma (battle)	43	0,37	5	0,08	1	0,01	2	0,03
Mine injuries	39	0,33	30	0,47	7	0,11	11	0,15
Non-war trauma	3	0,02	–	–	–	–	–	–
Burns	33	0,28	7	0,11	52	0,81	22	0,31
Snake bite, other bites, stin	7	0,06	1	0,01	–	–	–	–
Other injuries & poisoning	277	2,40	74	1.15	52	0,81	23	0,32
Total	11557	36,69	6425	20,39	6456	20,49	7065	22.43
acceptable error		±0,01		±0,001		0.00		-0,011
Drawing error		±0,05		±0,05		±0,05		±0,05
Total acceptable error		+0.06 -0.04		±0.05		±0,05		+0,04 -0,06



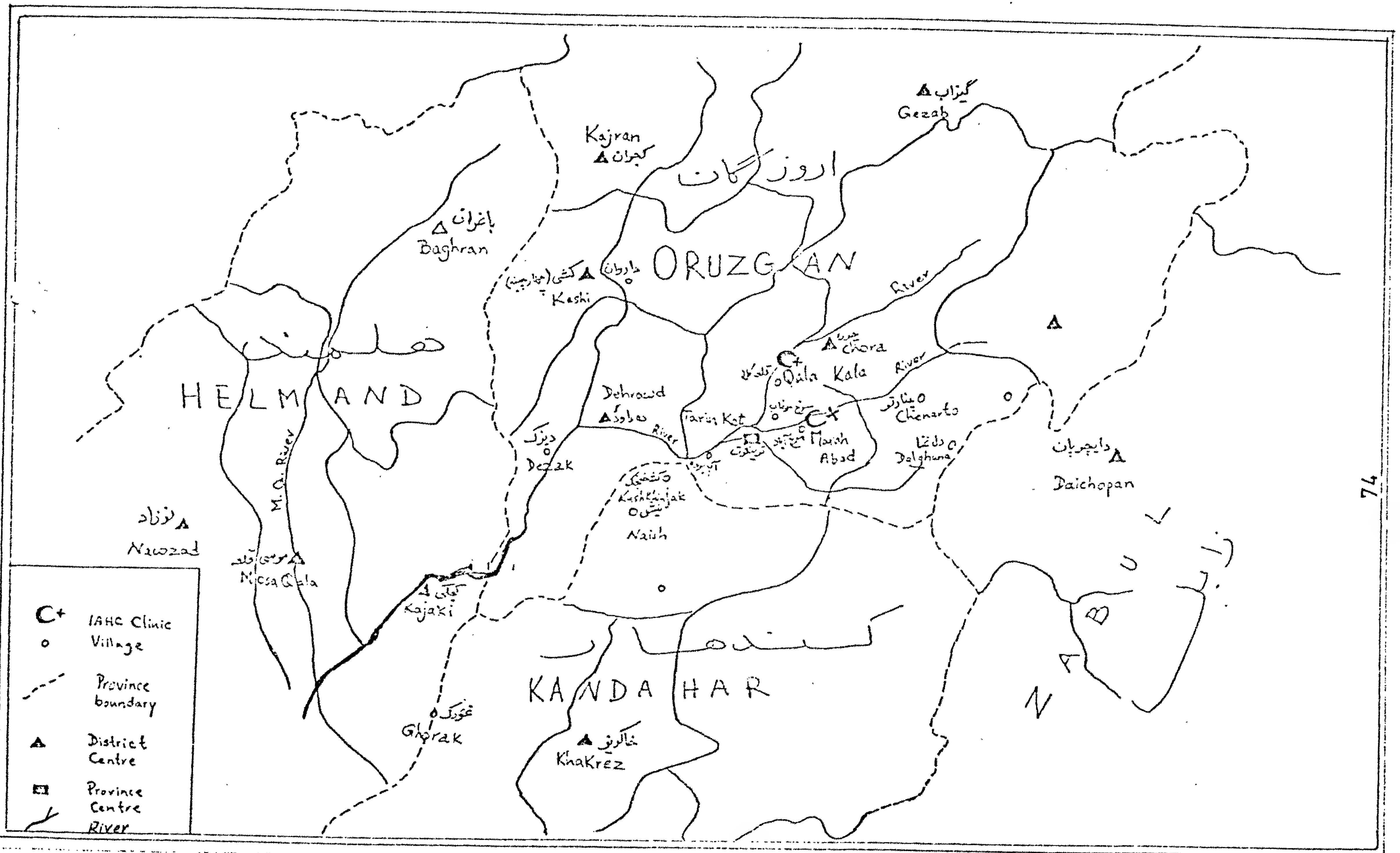
KANDAHAR Province,
Male.
Children 0-4 yrs
Female.
children 5-14 yrs.
Hospital/ clinic
Panjwai
Talokan
Sangesar
Arghistan
%
35
30
25
20
15
10
9
8
7
6
5
4
3
2
1
0,50
0,10
0.05
0.00
Cholera
Typhoid
Bacillary dysentry
Acute diarrhoea
Amoebiasis, Giardiasis
Measles
Whooping cough
Tetanus
Malaria
Intestinal worms
Scabies Lice
Other infectious & parasitic diseases
Malnutrition: protein
Other nutritional defic.
Anemia
Conjunctivitis
Trachoma
Otitis externa
Otitis media
Other nervous & sensory disorders
Hypertension
Other diseases of circulatory system
Common cold, rhinitis, URI
Tonsillitis (bacterial)& pharyngitis
Acute bronchitis
Pneumonia



KANDAHAR Province,
Hospital/ clinic
Panjwai
Talokan
Sangesar
Arghistan
Male.
Female.
Children 0-4 yrs
children 5-14 yrs.
%
35
30
25
20
15
10
9
8
7
6
5
4
3
2
1
0,50
0,10
0.05
0.00
Chronic bronchitis
Asthma
Other respiratory disor.
Toothache,dental abscess
Gastritis,hearburn,indi-gestion
Acute abdominal pain
Other diseases of the digestive system
Cystitis & urinary tract infection
Renal colic
Vaginitis, Gonorrhea & P.I.D.
Menstrual disorders
Other genitourinary disorder
Spontaneous abortion
Problems in pregnancy
Bacterial skin infection
Dermatitis & eczema
Other diseases of skin
Joint pain & arthritis
Backpain, lumbago
Headache
Body pain, total body pain
Fever
Weakness
Vomiting
Other symptoms, signs, condition
War trauma (battle)


KANDAHAR Province,
Hospital/ clinic
Male.
Female.
Children 0-4 yrs
children 5-14 yrs.
Panjwai
Talokan
Sangesar
Arghistan
%
35
30
25
20
15
10
9
8
7
6
5
4
3
2
1
0,50
0,10
0.05
0.00
Mine injuries
Non-war trauma
Burns
Snake bite, other bites,
Other injury & poisoning

Map focused on Oruzgan province



ORUZGAN

In Oruzgan Province IAHC runs two clinics, one is in Kala-e-Qala 30 km northwest of Tarin Kot (Oruzgan Capital) and other is in Mehrabad 35 km north east of Tarin-Kot.

There are no other health facilities in the area of these clinic for a distance of about 200 km. The residents which benefit from the clinic services, are widely scattered from each other because of geographical barriers.

Generally this region is mountanous and is 2000 m high above the sea level. The small villages lie along the valley floor and the area has a mountainous relief. There are basin-like deserts surrounded by high mountains, and the area is bounded by snow drifts. It has dry and hot summers, temperate autumns and sprins but cold and snowy winters. On average snow falls three to four times each winter. This condition applies only to southern and parts of central Oruzgan.

The temperature in summer rises to 37°C and in winter falls down to - 8°C . Thus , the winter in the area is windy with cyclonic winds in desert areas, blowing from the east to west, which are often dusty. The mountains have forests around which still remain undamaged.

The residential and agricultural areas in Mehrabad are stretched along the rivers banks and mountainous valleys. The water source of the area is Mehrabad river as well as springs flowing down the mountain slopes. The Mehrabad river which originates from Malistan Ghazni area, flows throughout the seasons, and creates some swamps along its banks. This water, from the middle of March up to the beginning of June, is muddy and used for both drinking and agricultural purposes. But because of high speed of this

water, it does not become polluted. The spring water which passes through the villages and is used by families, is more contaminated than the river water. Comparatively this area, however, has fine and clear weather.

The terrain is mainly mountainous with many trees and a lack of dust producing fertile land which contributes to the clear and unpolluted atmosphere.

As mentioned before, local people live in scattered small villages stretched along the valleys with sunlit houses. Many of the houses are built on the rocky slopes, so there is no moisture in their rooms. But the windows are still small which send out little dust from the rooms. The animals are kept in a similar style in Kandahar of Helmand. Taking care of the domestic animals , cleaning and feeding them are entirely the work of men.

This is a positive point for women, because they are enable to be more often in touch with their children. Men are frequently attending worship with ablution in mosques, therefore the chances of being affected by different diseases are reduced. The female allocation of work and home chores are less than in other areas.

Children are not as well cared for as in other areas. Babies are breast-fed and in later life they are fed with local food which the family can provide. They play in dust, drink stream water and eat unwashed fruits.

The local children are treated in different fashion, depending on the situation in which the familylives. Mothers play the major role in the treatment of their children.

From long ago it has become the custom that girls are not married before the age of 15 years, but the desire for having many children is still very strong. The result

of multiple child births by women, is the development of anemia and many other problems. TB is another outstanding problem among women which is increased because of limited availability of health services. Malaria has also not been prevented and there are many affected patients coming to clinics.

Lack of variety of food causes much malnutrition among the local children. An important problem is the incidence of diarrhoea which is called cholera by the local people. This is threatening not only Oruzgan, but northern Helmand especially in Safid-Hisar and Larkan areas. It spreads each year from June up to the middle of September. The geographical reason of the appearance of this cholera in Oruzgan or Helmand area is not clear. As the northern Helmand and Oruzgan is mountainous, therefore there are few chances for direct spread of this disease. Thus, movement of the local people rarely occure and each village has a natural barrier.

The level of education in general is the same for both men and women as in the neighbouring areas. No health education is being propagated and this lack of information of the local population has also contributed to the increase of different kinds of diseases.

Agriculture including livestock business is the major and overwhelming occupation of the local people. The staple crops of the area, are wheat, barley, peas, rice and vegetables. Orchards of different fruits and vineyards are also common. A large area is devoted for the cultivation of rice on the two banks of Mehrabad river. Since the rice farm require enough water to remain flooded for a long time, it also causes the emergence of malaria in the area.

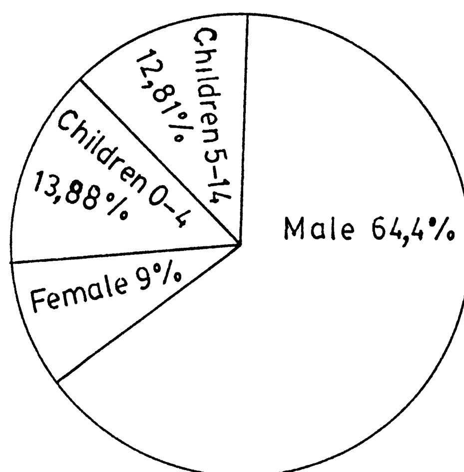
In the recent years the forests on the slopes of

mountains are not properly maintained. As the economy of local community has been disrupted so they are forced to eradicate the wild trees and bushes. It was also noticable that recently the orchards are being replaced by the wheat and other crop fields. Yet in comparison to Kandahar , Oruzgan is better in its environment.

The problems this area is facing are related to the transportation of the commodities especially in winters. The long distances and expensive cost of transportation causes the prices to rise steeply. The children especially become victims of high cost of food in the local bazaars.

Following this discription of the background of the area we will now present the data on the activities of the clinics in Mehrabad and Qala-e-Kala, which have treated a total of 14602 patients in 1990.

ORUZGAN PROVINCE



AFGHAN SOCIETY TODAY

Afghanistan is a multi-ethnic, multi-lingual state. Pushtuns, the largest tribe, constitute about 60 % of the population. They mainly inhabit the southeast and southwest of the country. Their language is Pushtu with some different dialects. Over 99 % of Pushtuns adhere to the Sunni Muslims School.

The second largest group is Tajiks. They are settled mainly in northern Afghanistan and Kabul city. Most of them are in Badakhshan, Parwan, Baghlan, Ghazni, Takhar, Mazar-e-Sharif, Herat and in some other provinces. Their language is Dari and they adhere to the Sunni School with Ismailia in Badakhshan.

Hazaras are thought to be the third largest group in Afghanistan. They have resided since the distant past in Bamyan and some other provinces, located in the central parts of the country. They were thought to be the remains of Changis Khan's army. But, recently however, experts proved that to be wrong. They are one of the eastern Turkic ethnic groups. Some are Imami Shias, some Ismailia Shias and a few are Sunni. They probably settled between 1229 - 1447 A.D. (Bacon 1951). Their language is dialect of Dari.

Uzbek is an ethnic group living in northern Afghanistan. They number about a million. Mainly sedentary agriculturalists. They speak Uzbeki, a Turkic dialect. They are all Sunni Muslims. Most of them immigrated as a result of the Russian invasion of Central Asia which began in 1734 (Louis Dupree 1980).

Turkamens are another branch of the Turkic ethnic group. They are mainly semisedentary and seminomadic people

Medical Report By Group Diseases

Province: Oruzgan

District(s): Terinkot, Chora

Year: 1990

	MEN	%	WOMEN	%	CHILDREN,0-4	%	CHILDREN,5-14	%
Cholera	70	0.74	12	0.93	2	0.10	7	0,34
Baciliary dysentery	622	6,61	30	2,30	280	13,91	183	9,75
Acute diarrhoea	700	7.44	83	6,34	449	22,30	220	11,74
Amoebiasis Giardiasis	213	2,27	42	3.21	78	3,87	92	4,90
Tuberculosis (all types)	–	–	–	–	3	0,15	1	0,05
Measles	–	–	–	–	23	1,14	2	0,08
Malaria	546	5,81	100	7,63	50	2,48	150	8,00
Intestinal worms	30	0,32	4	0,32	21	1,04	120	6,38
Scabies lice	10	0,11	–	–	–	–	–	–
Other infectious &parasitic	65	0,69	–	–	6	0,30	3	0,14
Malnutrition:protein,calori	14	0,15	7	0,54	70	3,45	23	1,20
Vitamin A deficiency xeroph	3	0,03	–	–	3	0,15	1	0,05
Goiter	10	0,11	15	1,16	–	–	6	0,30
Anemia	784	8,34	107	8,16	7	0,35	40	2,11
Conjunctivitis	184	1,95	74	5,65	152	7.55	65	3.45
Trachoma	13	0,14	3	0,24	2	0,10	1	0,05
Otitis externa	48	0,51	15	0,16	86	4,27	43	2,27
Otitis media	233	2,48	71	5.42	99	4,92	43	2,27
Other nervous & sensory dis	136	1,45	10	0,78	–	–	28	1,48
Hypertension	63	0,67	7	0,55	–	–	3	0,14
Other dis. of circulatory s	19	0,10	2	0,16	–	–	–	–
Common cold,rhinitis URI	801	8,52	60	4,58	46	2,29	20	1,05
Tonsilitis(bact)&pharyngitis	13	0,14	4	0,34	29	1,44	113	6,02
Acute bronchitis	500	5.32	15	1.16	105	5,22	45	2,40
Pneumonia	164	1,74	1	0.07	40	1.99	96	5.10
Chronic bronchitis	219	2,33	7	0,55	–	–	10	0,51
Asthma	19	0,20	7	0,55	5	0,25	2	0,10
Other respiratory sys.disor	106	1,13	2	0,15	46	2.29	20	1,07
Toothache dental abscess	37	0,39	–	–	–	–	4	0,20
Gastritis,hearburn,indiges	732	7,78	28	2,15	–	–	73	3,88
Acute abdominal pain	109	1,16	–	–	21	1,04	9	0,46
Other diseases of digestive	116	1,23	1	0,10	24	1,19	11	0,57
Cystitis &urinary tract inf	12	0,13	6	0,48	2	0,10	4	0,20
Renal colic	6	0,06	–	–	–	–	–	–
Vaginitis,Gonorhhea & PID	3	0,03	26	2.00	–	–	2	0.10
— — — — — — —	–	–	–	–	–	–	–	–
Other genitourinary disorde	26	0.28	76	5.80	4	0.20	14	0.71
Spontaneous abortion	–	–	21	1.62	–	–	–	–
Bacterial skin infection	134	1.42	3	0.25	21	1.04	48	2.51
Dermatitis & eczema	10	0.11	9	0.70	3	0.15	5	0.26
Other diseases of the skin	526	5.59	154	11.74	7	0.35	66	3,51
Jointpain & arthritis	119	1,27	33	2.53	–	–	11	0.57
Backpain lumbago	38	0.40	20	1,54	–	–	2	0.10

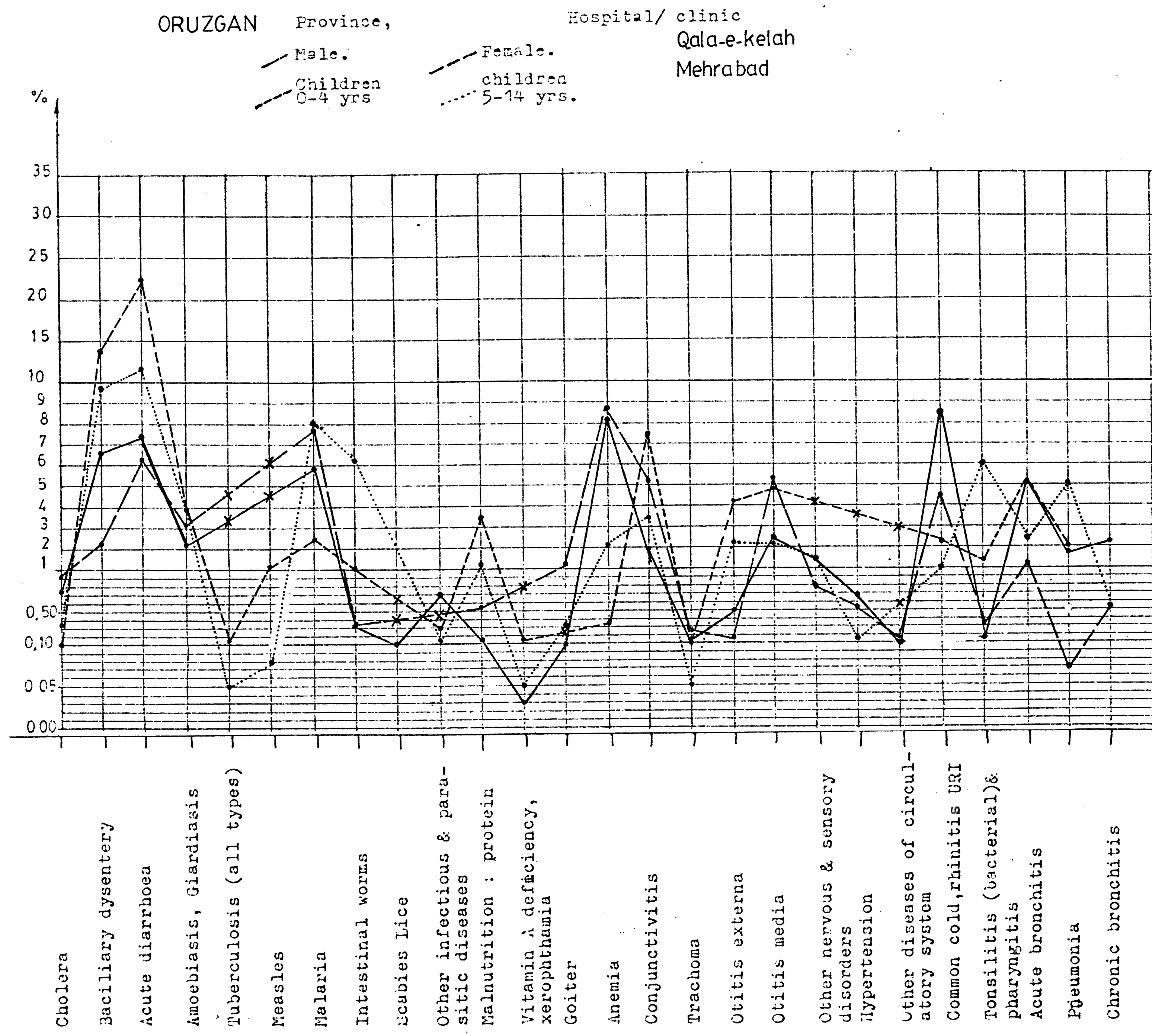
Medical Report By Group Diseases

Province: Oruzgan .

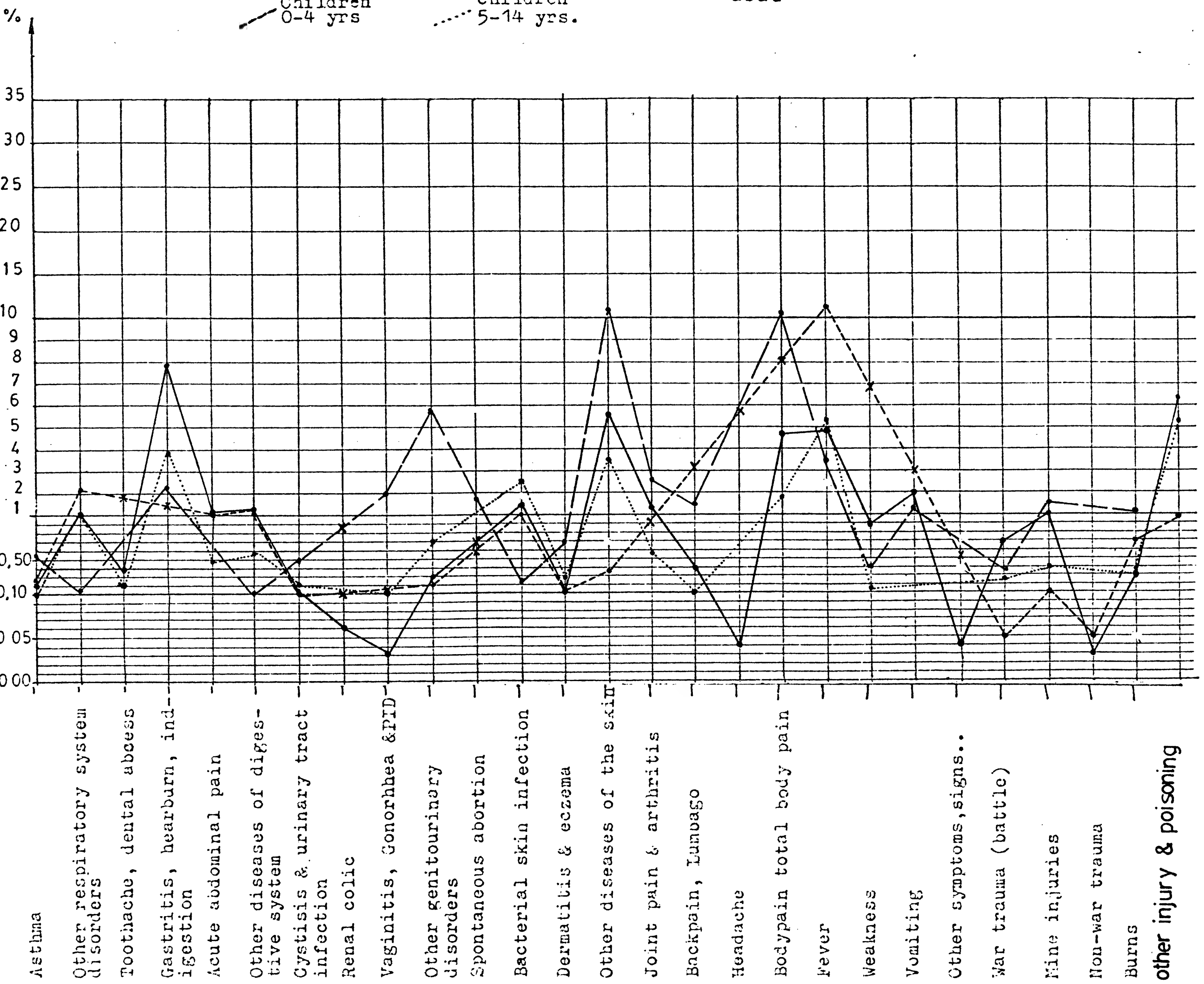
District(s): Terinkot, Chora .

Year: 1990

	MEN	%	WOMEN	%	CHILDREN, 0-4	%	CHILDREN, 5-14	%
Headache	4	0.04	—	–	—	—	—	—
Bodypain total body pain	443	4,71	150	11,43	—	—	35	1,85
Fever	456	4,84	45	3,44	228	11,33	98	5,22
Weakness	81	0,86	5	0,40	—	—	3	0,14
Vomiting	189	2,01	18	1.39	—	—	—	—
War trauma (battle)	64	0,68	6	0,48	1	0,05	5	0,27
Mine injuries	93	0,99	19	1,47	2	0,10	6	0,30
Non-war trauma	3	0,03	—	—	1	0,05	—	—
Burns	30	0,32	16	1.24	14	0,70	7	0,35
Other injury & poisoning	593	6,31	—	—	20	0,99	100	5.32
Other symptoms, signs, condit	4	0,04	-	-	-	-	-	-
total	9403	64,40	1314	9,00	2013	13,88	1872	12,81
Acceptable error		4×10^{-4}		+0,017		+0.02		-0.02
Drawing error		≈0 ±0.08		±0,08		±0,08		±0.08
Total acceptable error		±0.08		+0,10 -0,06		+0,10 -0.06		+0.06 -0.10



ORUZGAN Province,
Hospital/ clinic
Qala-e-kelah
Mehrabad
Male.
Children
0-4 yrs
Female.
children
5-14 yrs.
%
35
30
25
20
15
10
9
8
7
6
5
4
3
2
1
0,50
0,10
0.05
0.00
Cholera
Baciliary dysentery
Acute diarrhoea
Amoebiasis, Giardiasis
Tuberculosis (all types)
Measles
Malaria
Intestinal worms
Scabies Lice
Other infectious & para-
sitic diseases
Malnutrition : protein
Vitamin A defficiency,
xerophthamia
Goiter
Anemia
Conjunctivitis
Trachoma
Otitis externa
Otitis media
Other nervous & sensory
disorders
Hypertension
Other diseases of circul-
atory system
Common cold,rhinitis URI
Tonsilitis (bacterial)&
pharyngitis
Acute bronchitis
Pneumonia
Chronic bronchitis



ORUZGAN Province,
Hospital/ clinic
Qala-e-kelah
Mehrabad
Male.
Female.
Children 0-4 yrs
children 5-14 yrs.
%
35
30
25
20
15
10
9
8
7
6
5
4
3
2
1
0,50
0,10
0 05
0 00
Asthma
Other respiratory system disorders
Toothache, dental abcess
Gastritis, hearburn, indigestion
Acute abdominal pain
Other diseases of digestive system
Cystisis & urinary tract infection
Renal colic
Vaginitis, Gonorhhea &PID
Other genitourinary disorders
Spontaneous abortion
Bacterial skin infection
Dermatitis & eczema
Other diseases of the skin
Joint pain & arthritis
Backpain, Lumbago
Headache
Bodypain total body pain
Fever
Weakness
Vomiting
Other symptoms, signs..
War trauma (battle)
Mine injuries
Non-war trauma
Burns
other injury & poisoning

QUETTA, BALUCHISTAN.

Baluchistan is a province of Pakistan in the south-west of the country (347,188 sq kms). Quetta city is its capital. It is mountainous in the north and desert covered its western parts. It is the driest province of Pak because rainfall is inefficient and irrigation is an absolute necessity. Few seasonal rivers are flowing through Baluchistan. It has about (1,120 km) border with Afghanistan.

The major languages spoken here are Pushtu and Baluchi with some minority dialects. Baluchistan in comparison to other provinces, has 13 % literate population (Pakistan Studies, 1986). Major population is constituted by different tribes especially in the north and north-west.

According to WHO Pak branch, generally in Pakistan health distribution are understood as below :

- 1 doctor for 3,600 persons.
- 1 nurse for 6.4 hospital beds.
- 1 paramedic for 1,936 persons.
- 1 bed for 1,572 persons.

The influx of refugees started from 1978 until their no reached by the end of 1991 to about, according to UNHCR , 300,000 only in Baluchistan Province. The refugees are of different ethnic groups, such as Pushtun, Uzbek, Turkamen, Tajik, Baluch and Hazaras.

According to the Commissionary for Afghan Refugees, the total number of Unregistered Refugees is 6151 families (or 36,906 persons) of which Ghous Abad and Satellite Town have been estimated to have 2083 families living close to IAHC OPD clinic. Most Non Registered Afghan Refugees (NRAR) according to MSF Survey Report, January 1991, belong to

the Pushtun tribe (44 %), while Uzbek form the second largest group with 26 %. Later this report says that the big majority (82 %) lives in tents. The rest live in mud houses which they built themselves. According to UNHCR, 3 % of the people who live in the areas of NRAR, were registered. Recently, since the registered refugees are getting less aid than before, they come to the big cities esp Quetta, so their number is day by day increasing.

According to MSF survey, 77 % of the men are working, but not in a full time job. The great majority 92 % are working as labourers and are on daily basis which is not regular at all.

As expected, few male are literate while none of the women are literate. Very few percent of the children of NRAR are being enrolled and they are only boys.

Since the majority of NRAR are living in tents, they suffer from different kinds of problems related to accommodation. Few families have made latrines close to their tents. Often the tents and floor are wet especially in winter and spring. Children and other family members sleep on moistured ground. The level of sanitation is very low. According to MSF water source is for most people (94 %) a well. This is not a prtected well, but just a deep hole in the ground. About 1 % get their water from neighbouring Pakistani.

The case with health services is that most of the men and women goto the clinics or hospitals established for NRAR in Quetta. Average payment for private doctor is 100 rupees. While in the clinics which are for refugees, the average payment is 10 rupees. To almost all NRAR, health facilities are accessable. Women, in general can attend the clinic especially when men accompanying them. In most of the clinics run by NGOs, the medicine are free

of costs.

The health problems according to MSF survey is that in general the NRAR are having more problems than refugees who are registered. For example 16 % of the children had died before the age of 5 years. The causes of death of the children were diarrhoea (30 %), Acute Respiratory Infection (ARI) 13 % and the rest are unknown. Different seasons raise different diseases. ARI in winter and autumn, the diarrhoeal problems raise in summers.

As it is expected women's health condition is also worse. Deliveries take place at home for about 97 %. According to MSF survey 47.8 % of women are assisted by family members. In a high percentage (15 %) the cord was cut by woman herself. Only for 37 %, the delivery was assisted by a dai (TBA). It proves that the perinatal care for NRAR is minimum.

As the diet of many of NRAR is poor, the evident result is that malnutrition is higher among children. For example, according to MSF survey, 11 % of children are severely malnourished and 37% mildly.

Gastritis seems to be the highest in men and secondly in women. Having interviewed OPD Head Doctor, he said that the causes of gastritis are mainly mental pressures and taking irritational food (e.g. bitter or spicy male). There are however, other causes of gastritis as well.

Vaccination, however, is almost certainly optimistic. Though in comparison to registered refugees, the NRAR are not fully immunized. But still most of women & children are being immunized. For more information about vaccination please refer to IAHC EPI report as well as MSF survey report among NRAR, Jan 1991.

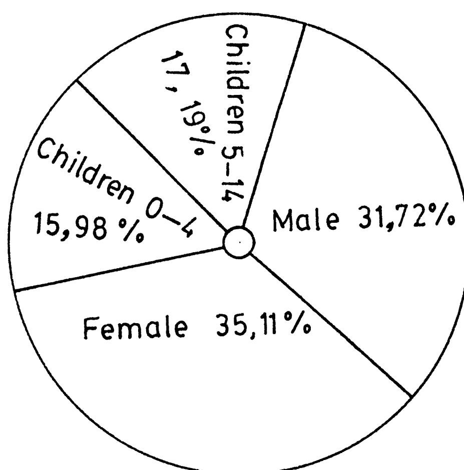
As mentioned before, many diseases spread or increase

when there are no proper protection in terms of health, lack of sanitation, inadequate diet, lack of perinatal care, no safe water and the existing of other problems.

As such opportunities exist already, these health problems are certainly the result of those conditions. To solve these problems, comments are given at the end of this book under the title of Conclusion.

Following this description of the background of the NRAR we will now present the data on the activities of IAHC OPD clinic in Quetta, which has treated a total of (20,347) patients in 1990.

OPD QUETTA



Province: Baluchistan

District: Quetta, OPD Clinic

Year : 1990.

	MEN	%	WOMEN	%	CHILDREN, 0–4	%	CHILDREN, 5–14	%
Baciliary dysentery	135	2.11	102	1.40	321	9.97	210	6.06
Acute diarrhoea	66	1.03	110	1.51	750	23.30	360	10.40
Amoibiasis, Giardiasis	88	1.38	79	1.09	74	0.30	150	4.33
Tuberculosis (all types)	23	0.36	23	0.32	–	–	5	0.15
Measles	–	–	–	–	34	1.05	–	–
Whooping cough	–	–	–	-	10	0.31	–	–
Tetanus	–	–	1	0.01	–	–	–	–
Malaria	52	0.81	61	0.84	6	0.19	20	0.58
Intestinal worms	39	0.61	48	0.66	20	0.62	120	3.46
Scabies lice	30	0.47	25	0.34	10	0.32	15	0.43
Malnutrition:Protein,calorie	5	0.08	20	0.28	107	3.22	15	0.43
Goiter	–	–	10	0.14	–	–	–	–
Other nutritional deficien.	43	0.67	70	0.96	20	0.62	10	0.29
Anemia	200	3.13	1260	17.32	300	9.32	321	9.27
Nervous &sensory sys. disord	42	0.66	30	0.41	–	–	10	0.27
Conjunctivitis	152	2.35	130	1.79	180	5.59	125	3.61
Trachoma	7	0.11	10	0.14	–	–	8	0.23
Otitis externa	17	0.26	16	0.22	30	0.93	64	1.85
Otitis media	15	0.23	18	0.25	35	1.09	65	1.88
Hypertension	415	6.49	469	6.63	–	–	–	–
Other dis. of circulatory s	97	1.52	110	1.51	–	–	42	1.21
Common cold,rhinitis URI	874	13.67	971	13.35	500	15.53	544	15.71
Tonsilitis(bact)&pharyngitis	127	1.99	120	1.65	20	0.62	110	3.18
Acute bronchitis	562	8.79	382	5.25	362	4.25	300	8.66
Pneumonia	47	0.74	38	0.52	28	0.87	20	0.58
Chronic bronchitis	300	4.69	196	2.69	–	–	6	0.17
Asthma	293	4.58	195	2.68	20	0.62	30	0.87
Toothache ,dental abscess	50	0.79	40	0.55	–	–	10	0.29
Gastritis,hearburn,indiges	982	15.36	769	10.57	–	–	50	1.44
Acute abdominal pain	56	0.78	102	1.40	39	1.21	16	0.46
Other dis. of digestive sys	73	1.14	65	0.89	10	0.31	17	0.49
Cystitis &urinary tract inf	130	2.03	150	2.06	10	0.31	56	1.62
Renal colic	85	1.33	24	0.33	–	–	15	0.43
Vaginitis,Gonorhhea & PID	16	0.25	153	2.1	–	–	5	0.15
Menstrual disorder	–	–	70	0.96	–	–	10	0.29
Spontaneous abortion	–	–	15	0.21	–	–	–	–
Problems in pregnancy	–	–	90	1.24	–	–	–	–
Post-partum problems	–	–	40	0.55	–	–	–	–
Bacterial skin infection	134	2.09	124	1.70	7	0.22	100	2.89
Dermatitis &eczema	207	3.24	178	2.45	18	0.56	20	0.58
Other diseases of the skin	33	0.51	33	0.45	49	1.52	200	5.77
Joint pain & arthritis	580	9.07	500	6.87	–	–	26	0.75
Backpain lumbago	95	1.48	120	1.45	–	–	17	0.49

in northern Afghanistan. They brought with them the Qarakul sheep (Persian lamb) and Turkamen rug "Qaleen" manufacture to Afghanistan in 1920s. They are Hanafi Sunni and speak Turkic dialect.

Aimaq, one of a Turkic branch. "Aimaq" literally means "tr ibe" in Turkic language. Mainly involved in farming and as labourere in southwestern provinces of Afghanistan, especially in Badghis and Herat. They speak Dari dialect with much Turkic vocabulary. All Aimaqa are adherent to Hanafi Sunni School.

Baluch, another Indo-Iranian ethnic group spread to the southwest of the country in the area neighbouring Baluchistan province of Pakistan. They speak Baluchi and are adherent to Sunni Islam school. They are mainly invo-lved in keeping livestock and some own small tracts of land. They are concentratedin southern Helmand, Nimroz, Farah, and southwest of Kandahar province. The other branch of Baluchi is called Baruri. All of them are Sunni Muslims.

The Noristanis who are thought to be the descendants of Alexander the Great's army, constitute a small minority in the northeastern Afghanistan. They have kept their very ancient culture for centries. Experts in history, named them Graco-Bactarians. They were converted by A. Rehman in to Islam (Sunni School), (1895). The majority of these people are herdsmen and have still kept their culture with many valuable arts in their tradition. They speak Pashai language.

Hindus and Sikhs inhabit some cities of the country. They are mainly involved in trading, importing and expor-ting to India, and some have business with Japan, Russia etc.

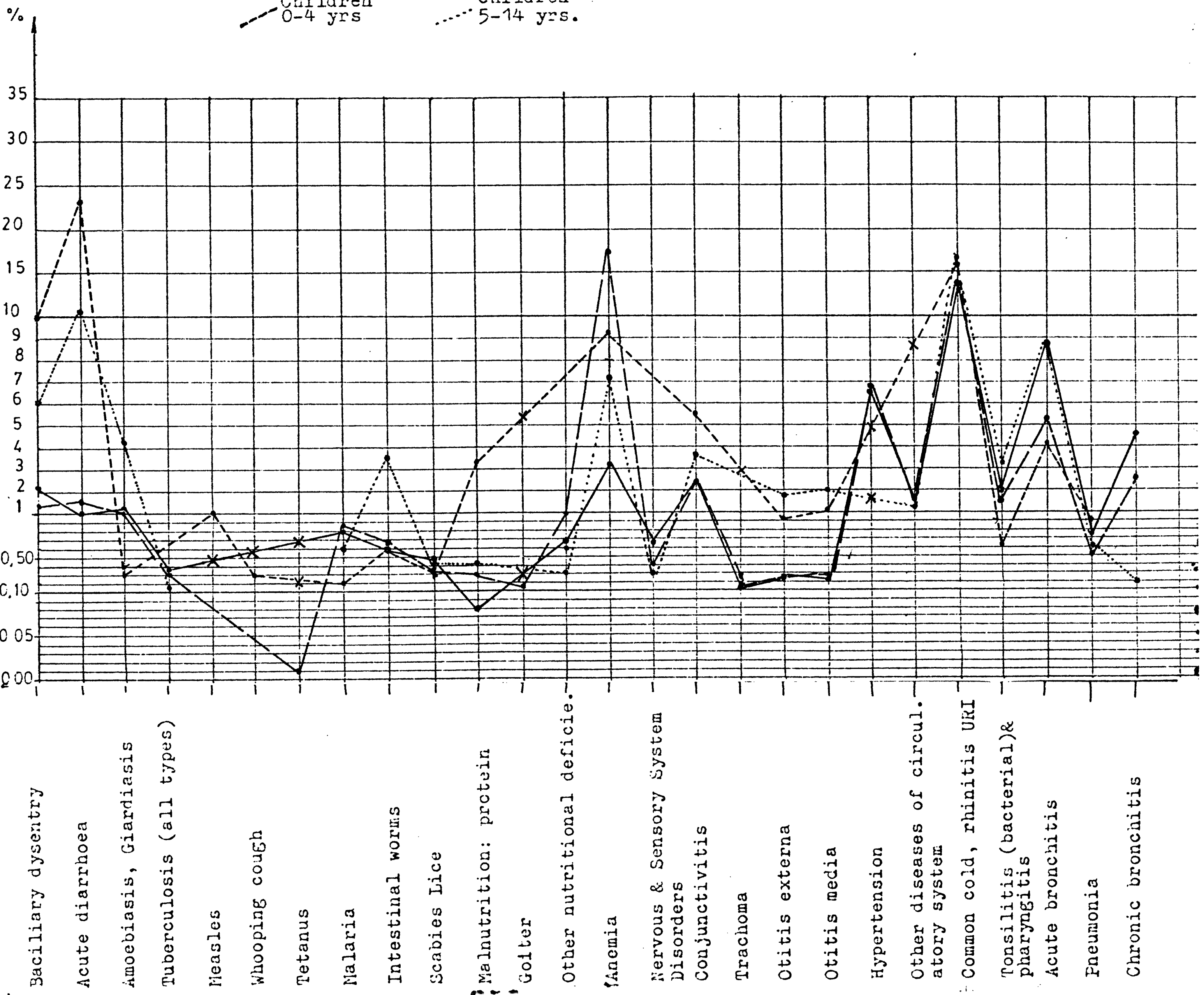
Medical Report By Group Diseases

Province: Baluchistan

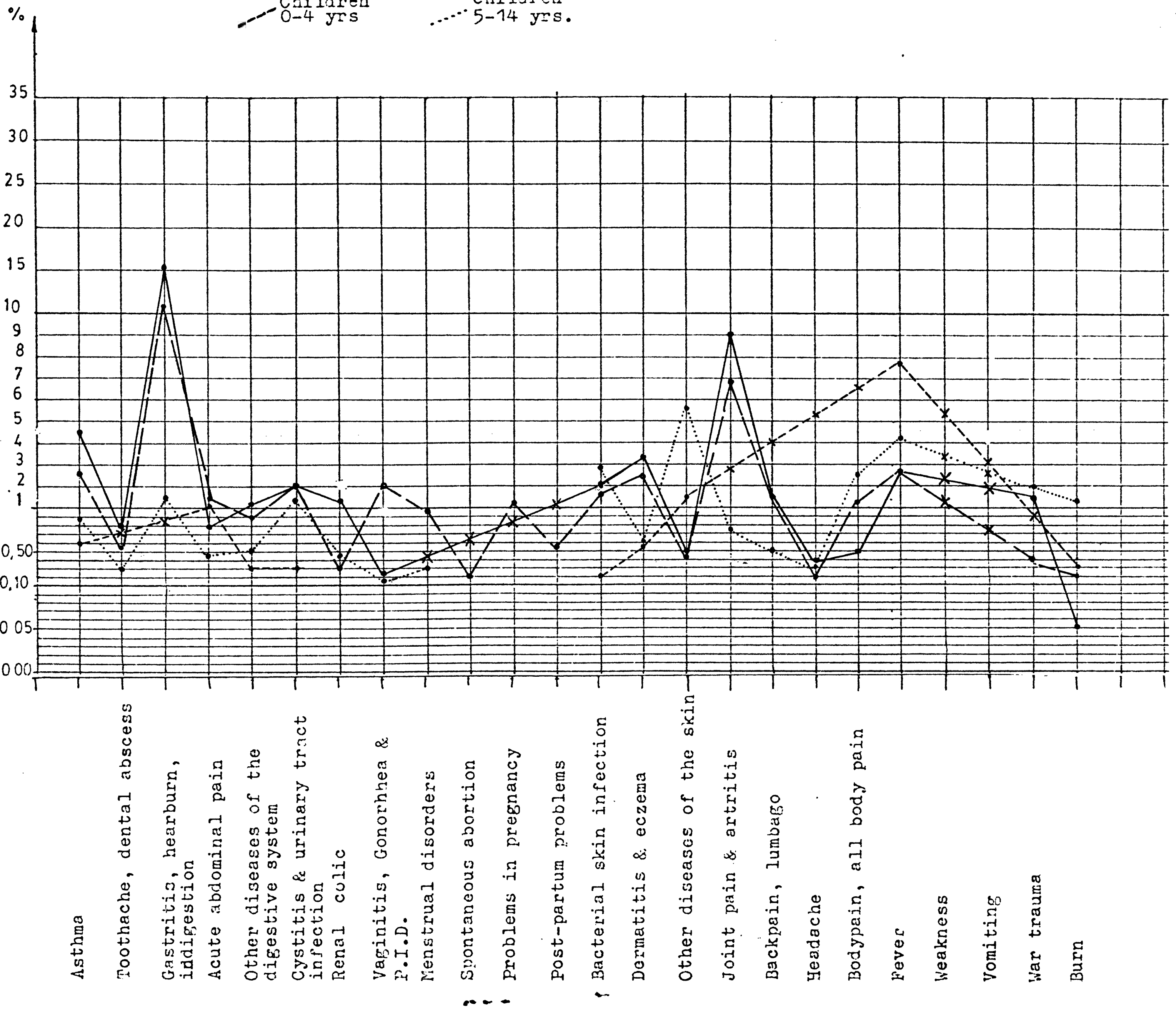
District: Quetta, OPD Clinic

Year : 1990.

	MEN	%	WOMEN	%	CHILDREN, 0-4	%	CHILDREN, 5-14	%
Headache	25	0.39	15	0.21	—	—	10	0.29
Bodypain, total bodypain	35	0.55	90	1.24	—	—	90	2.60
Fever	175	2.74	159	2.6	250	7.77	150	4.33
War trauma (battle)	91	1.42	28	0.38	—	—	68	1.96
Burns	3	0.05	15	0.21	9	0.28	50	1.44
Total	6391	31.72	7274	32,19	3219	15.98	3463	17.19
Acceptable error		$1{,}25\times10^{-3} \cong 0$		$\cong 0.00$		0,00		$\cong 0$
Drawing error		±0,08		±0,08		±0,08		±0,08
Total acceptable error		±0,08		±0,08		±0,08		±0,08



BALUCHISTAN Province,
Hospital/ clinic
O.P.D Quetta
Male.
Female.
Children 0-4 yrs
children 5-14 yrs.
%
35
30
25
20
15
10
9
8
7
6
5
4
3
2
1
0,50
0,10
0 05
0 00
Baciliary dysentry
Acute diarrhoea
Amoebiasis, Giardiasis
Tuberculosis (all types)
Measles
Whooping cough
Tetanus
Malaria
Intestinal worms
Scabies Lice
Malnutrition: protein
Golter
Other nutritional deficie.
Anemia
Nervous & Sensory System Disorders
Conjunctivitis
Trachoma
Otitis externa
Otitis media
Hypertension
Other diseases of circul. atory system
Common cold, rhinitis URI
Tonsilitis (bacterial)& pharyngitis
Acute bronchitis
Pneumonia
Chronic bronchitis



BALUCHISTAN Province,
Hospital/ clinic
O.P.D Quetta
Male.
Female.
Children 0-4 yrs
children 5-14 yrs.
%
35
30
25
20
15
10
9
8
7
6
5
4
3
2
1
0,50
0,10
0 05
0 00
Asthma
Toothache, dental abscess
Gastritis, hearburn, indigestion
Acute abdominal pain
Other diseases of the digestive system
Cystitis & urinary tract infection
Renal colic
Vaginitis, Gonorhea & P.I.D.
Menstrual disorders
Spontaneous abortion
Problems in pregnancy
Post-partum problems
Bacterial skin infection
Dermatitis & eczema
Other diseases of the skin
Joint pain & artritis
Backpain, lumbago
Headache
Bodypain, all body pain
Fever
Weakness
Vomiting
War trauma
Burn

Chapter III

Conclusion

CONCLUSION

During the course of 1990, the IAHC clinic in four provinces and the Quetta OPD clinic have examined and treated altogether a total of 1,42,826 patients,consisting of men, women and children of all ages. As mentioned before, these health units are in Ghazni, Kandahar, Helmand and Oruzgan Provinces. The patients being researched are in addition to those wounded who received dressing services in IAHC dispensaries of which there are in total 28 in Helmand and Kandahar Provinces, which are supplied with B unit medicine. Clinics and hospitals use A units which mainly consist of curative medicine.

By the year 1990, all the clinics and hospitals have used (62.81) A unit medicine. To know how the patients are treated, according to their sex and age, please see the table presented on the next page.

Having analysed the table, the range of diagnoses for women diseases is the highest, while children's (0-4 yrs) is the lowest. This data is obtained from the registers of the patients coming to the clinics (see graph & table). From the table which determined the effeceincy of the clinic as determined by amount of medicine need per patient, we can see that the OPD clinic in Quetta has the highest level of efficiency as it used one A unit medicine for the treatment of (2,907) patients. Other clinics' efficiencies are fixed relative to OPD clinic in Quetta. The Polyclinic inside Afghanistan is the highest in its efficiency level and Oruzgan on the contrary has the lowest.

These differences are probably explained by the fact that the health workers in Afghanistan are less experienced and less trained than the MD in Quetta OPD and as they are less confident of their diagnoses they prescribe many

Province	Total Patients in 1990	Diagnoses according to sex & age.			
		Male	Female	Children 0-4y	Children 5-14y
Ghazni	30151	51	54	38	48
Helmand	56259	49	49	43	51
Kandahar	31503	50	48	39	45
Oruzgan	14602	50	42	36	44
Quetta O.P.D	20347	41	46	28	40
Total	142862	48,2	47,8	36,8	45,6

PROVINCE	PATIENTS	MEDICINE(A unit)	Effective Coefficiency of Treatment, $K_{ect} = \frac{\text{patient}}{\text{unit A}}$
Ghazni	30151	12	2512,58 86,44%
Helmand	56259	23	2440,83 or 83,97%
Kandahar	31503	13,5	2333,56 -"-80,28%
Oruzgan	14602	7	2086 -"- 71,76%
Quetta OPD	20347	7,306	2906,71-"- 100 %

different medicines for the treatment of a disease. This results in the relative inefficiency of the work of the clinics. Some individuals use their influence and position in the community to get more medicine which is unnecessary, and this is again related to the qualification of health workers. They may fail to convince the patients that medicine is not needed. In some cases the real patients are not treated.

After the analysis of the graphs of incidence of different diseases, we can see that dairrhoeal problems have the highest incidence and are the most wide spread diseases among all the classes of the patients registered in IAHC clinics.

In the case of children, the numbers affected are higher than registered as often they are not brought to the clinic or are not diagnosed. It is not yet possible to diagnose accurately however, what is the exact cause of this problem, since there is no equipped lab with qualified lab technicion in the area to analyse the necessary specimens for diagnosis. This is an urgent need if the clinics are to diagnose and treat diarrhoeal diseases appropriately.

From an ecological point of view , we strongly believe that the water sources are the major sources of infection and the drinking water, vegetables and fruit should be prepared and consumed in a hygienic fashion to counteract this. This matter is potiencially related to the level of education and health propaganda in Afghanistan.

Amoebic dairrhoea is also, according to IAHC registers, the most common problem affecting all the classes of the patients especially children from (0-15) years. This problem also relates mainly to contaminated water which is not well protected and prepared and families which do not

take care to prevent their children being infected.

Tuberculosis is another major health problem and because of its contagious nature, its control is a serious problem. In Kandahar and Oruzgan with the exception of Arghistan clinic, there are no lab facilities to diagnose TB, therefore, in these places TB is not registered. In Helmand and Quetta incidence of TB is very high in women and in Ghazni, children of (5-14) years are most commonly affected. The main ecological factors in its causation are the scarcity of food items and overcrowded living conditions. To prevent TB, BCG vaccination is needed and to control it requires a complete set of treatment and then the hygienic rules (e.g. segregation of patient,sunshine and fresh air in the room of the patient, and sterelizing the dishes etc) and health education play major role to the control of this fatal disease.

Measles, whooping cough, tetanus and leprosy are problems which are of less common incidence according to the registers, but measles in the provinces of Helmand, Ghazni and Kandahar causes deaths among children esprecially at the age between (0-5) years. The major preventive measures for these diseases are immunization and correct diagnosis and course of treatment in the case of leprosy in all four provinces.

Malaria is registered in the clinics of the four provinces and for all the classes of patients as well as in Quetta Pakistan. The affected are mainly children of (5 - 15) years. In Quetta the number of women affected by malaria, is higher and in order of incidence of diseases, malaria is the sixth commonist diagnosis. Malarial mosquitoes are solely responsible for this problem. Similarly leishmania is caused by sand-fly bites which have been common in Kandahar for a long time. The scar left by the

infection, remains forever. The breading of the malarial mosquitoes is not controlled, so each year these swamps increase and cause an increasing number of cases of malaria. For the present time, medicine for the treatment of malaria must be combined with spraying of D.D.T. powder or malatyen, fastening of nets on the windows and finally killing mosquitoes inside rooms before going to bed which all will help to decrease incidence of this disease.

Panjwai, Maiwand and Arghandab areas as well as the meanders of Dorai river, Kokaran, Deh Kochi in Panjwai district, swamps in Safid-Rawan and eastern parts of Zang Abad upto Doray river, mires in Qulf-Sulwaghi, Takhta - Pul on the two sides of the river, are all places where mosquitoes lay eggs and therfore require spraying with anti-malarial powders. Also there is a kind of fish called Gambozia which eats the malaria eggs which is an economic way of eliminating mosquitoes.

In north Helmand, malarial sources are the two sides of Mosa-Qala river and Nowzad areas. The best time for spraying powder is July upto the end of August, as this time mosquitoes lay eggs and can spread to other areas.

The same is the case with Oruzgan where both swamps and rice fields produce this enemy of human.

According to the graphs, the highest number of malaria affected patients live in Helmand, Kandahar and then Oruzgan. The lowest is in Ghazni. Again children of(0 -5) years are the major victims of this disease.

Intestinal worms is another very common problem which includes all the classes of patients. Children of (0 - 5) years are the most commonly affected by this pro-

blem which men and women have little of intestinal worms. From the ecological point of view, this problem relates to lack of safe water and vegetables which are not washed properly due to lack of knowledge about rules of sanitation.

Malnutrition is another major and common problem registered in all the clinics. This is the result of the continuous war causing a scarcity of food items and animal productions especially protein. Inflation is also involved which has reduced the ability of people to buy produce in the market. The highest insidence , however, of malnutrition is in Quetta and Oruzgan. Certainly children of (0-5) years are the most affected and mothers are the next commonest victims of this problem. Mothers and their children are often both affected by this problem due to their close relationship, especially those mothers having several births and marriage at a young age.

Anemia is a health problem affecting a high percentage of mothers. According to the list of diseases registered , anemia is the third commonist in insidence. Quetta OPD shows the highest number while Kandahar and Ghazni have second highest insidence of anemia. Helmand and Oruzgan registers are not as reliable in this case, because women make up a small percentage of those coming to the clinics. As discussed already the factors involved in the causation of anemia are many. The cultural factors are early marriage, frequent deliveries, abnormal deliveries and lack of mother and child care. The other common cause is pathological, due to chronic diseases such as malaria, dysentry, bleeding from a wound and lack of good or nutritious food. This problem is commonist in women and then in children of (0-5) years which should be seriously considered.

Gastritis is also a common disease in all the clinics. The provinces show high number, in order are: OPD Quetta, Kandahar and Helmand but Oruzgan and Ghazni show lowest number of the patients having gastritis. The causes include mental pressures and eating indigestible or irritational food.

Preqnancy and gynaecological problems are not treated in a satisfactory manner due to the lack of female health workers. Women problems are examined in the clinic less commonly while they (women) make the half of the community which have more or less these problems.

Bodypain which is generally undefined and may be a symptom of many different diseases, shows a high insidence in the registers. All the catagories of patients complain of this and because of lack of specialists inside Afghanistan it is not analysed to find what is the exact problem causing the pain. It is a symptom that is registered, not a disease itself. There are other symptoms such as headache, fever, sleeplessness and general weakness which are registered in IAHC clinics. This reflects the level of training of health workers and equipment available which are not adequate to diagnose the real problems causing these symptoms.

Injuries including war wounds, mine explosions, burns, stings and unconciousness are often registered in all the clinics, especially injuries caused by mine explosions and other similar incidents. In Ghazni, Kandahar and Oruzgan men are most often affected while in Helmand women and in Quetta, children are the victims of these accidents. Each province has its own peculiarities.

Typhoid has been registered only in Ghazni province and in all the categories of the patients. This is the

There are about 2,000,000 nomads of which 80 % are Pushtuns. The remainder are mainly Baluchs.

There are some other very small ethnic groups in Afghanistan which do not make up a considerable part of the population and are cheifly absorbed in the local communities. Namely, they are Gujar, Arab, Jat and Jews (who are said to have left the country for Israil).

Lack of mobility and the continuous involvement of communities in working the land scattered far away from each other, made the tribes separate and develop different cultures. The isolation of each tribe in a specified area, forced them to have stronger ties within themselves, especially in marriage, mobility, and the lack of settlment in other communities.

This is why a large number of the population remained unaware of the rest of the world, even from other villages in the neighbourhood.

The low level of technology and unchanged traditional life, as well as political pressures which have been applied by past governments, from outside up to the present time, have also been responsible for the very slow progress of Afghanistan.

The family is a very important unit in Afghan society. Character, dignity, moral, standards etc of an individual are related to his/her family (Hanne Christensen UNRISD , 1990). Thus the family is proud of being a descendent of a large powerful and wealthy tribe. In fact the society is such a net that an individual can not be considered a person in his/ her own right. If a thread (a person) of this net (society, tribe or community) is broken then the person would suffer for the rest of his/her life.

In Afghanistan, land ownership and landlords, influence

Islamic Aid Health Centre

Health Problems Inside Afghanistan

Evaluation & Monitoring Report of IAHC Medical Activities in Afghanistan & Pakistan

Produced by
IAHC Head Office
December 1991

PREFACE

Islamic Aid Health Centre (IAHC) as an Afghan NGO considered it necessary to revise and go through all of its medical projects activities inside Afghanistan studying the impact on the communities in the field of health, economy, politics, social affairs and other general information on the conditions of Afghan women, children and the education.

The impact is illustrated in figures obtained from several project medical reports with assessments covered by IAHC and other interested NGOs.

This year (1991) IAHC has decided to gather data by the revision of medical reports received from its projects both in Afghanistan and Quetta Pakistan.

On the one hand to rehabilitate Afghanistan is the higher priority, however, this work in such war torn areas, with many different kinds of problems in the communities, makes the organization of projects quite complicated.

When the results of the activities of medical projects inside Afghanistan are considered, IAHC during the course of 1991 has managed its programmes in such a way that has resulted in either partial or complete solutions of some of inefficiencies of the inside medical projects.

The establishment of medical refresher courses, the introduction of the new system of patient registration, more emphasis on upgrading the level of EPI programme, starting lab training for MLHWs inside Afghanistan, upgrading the level of MLHWs especially in TB , Malaria and Mother & Child Healthand finally periodical and long term

assessment of the medical activities of each project by a medical specialist are the actions which are hopefully contributing to the solution of some of the problems which are mentioned in this book.

This book has been made available to you through the efforts of the colleagues of inside projects and the related offices in Quetta Pakistan especially the office of health data evaluation, technical sup and IAHC medical administration have continuously committed efforts in the preparation of this book. Their contribution is highly appreciated .

I hope that this book will be useful to both IAHC and to those who are involved in the rehabilitation programmes of Afghanistan. Any suggestions or opinions from the readers of this report are welcomed.

Dr A.B.Haqani

December 1991.

CONTENTS

Chapter I

A Short Historical Background